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Missouri Medicine

Journal of the Missouri State Medical Association August 1993

1993 - 1994
Missouri State Medical Association
Membership Directory

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MISSOURI MEDICINE

VOLUME 90, NUMBER 8

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AUGUST COVER:

"Bluffs and River" - 22" x 26" acrylic paint on canvas is by St. Louis artist, John O'dell. Mr. O'dell is a regular contributor to *Missouri Medicine*, this being his fifth directory issue cover. The view is of the Missouri River from the Weldon Springs Overlook. The overlook can be reached by hiking trails below the bluffs from the Katy Trail.

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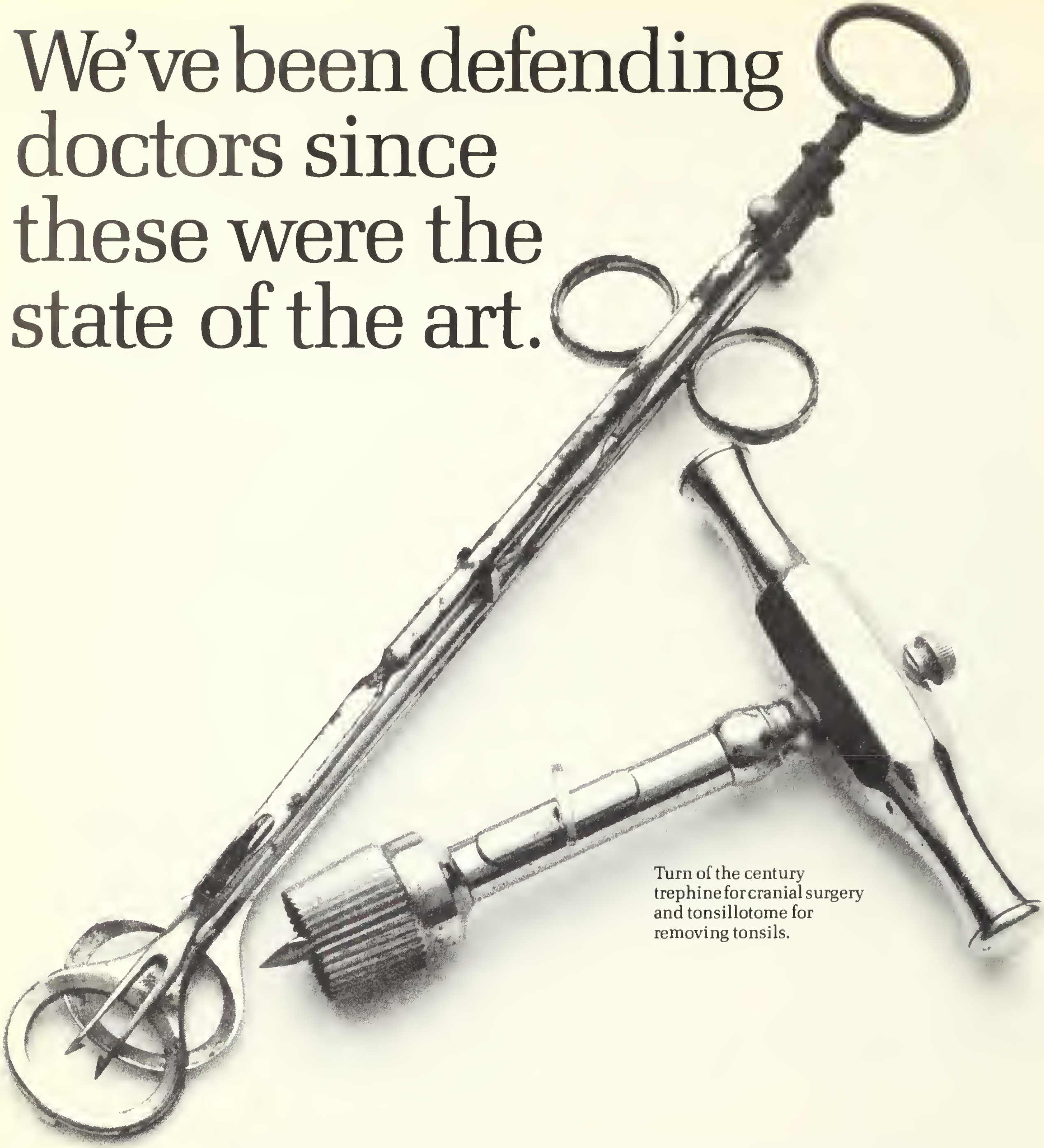

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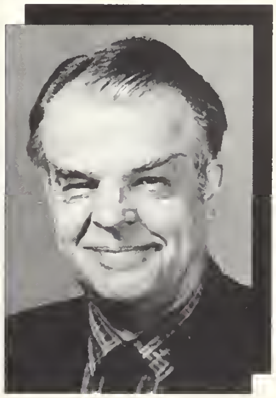

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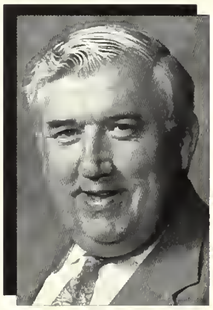
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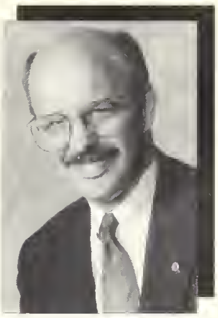

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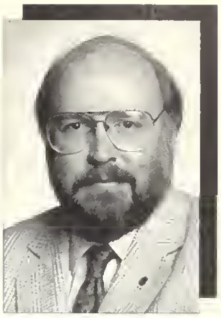

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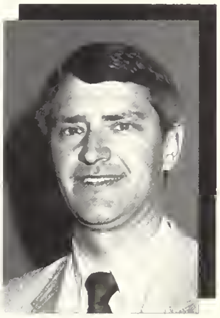

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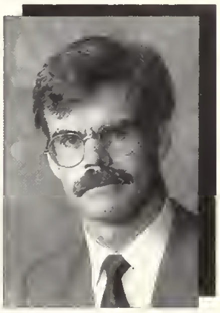

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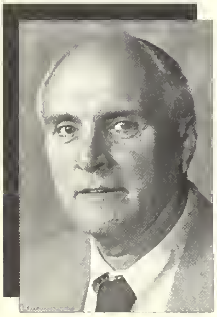

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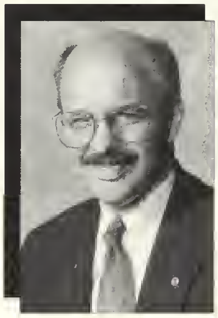

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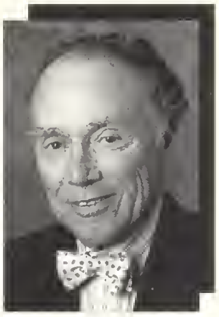

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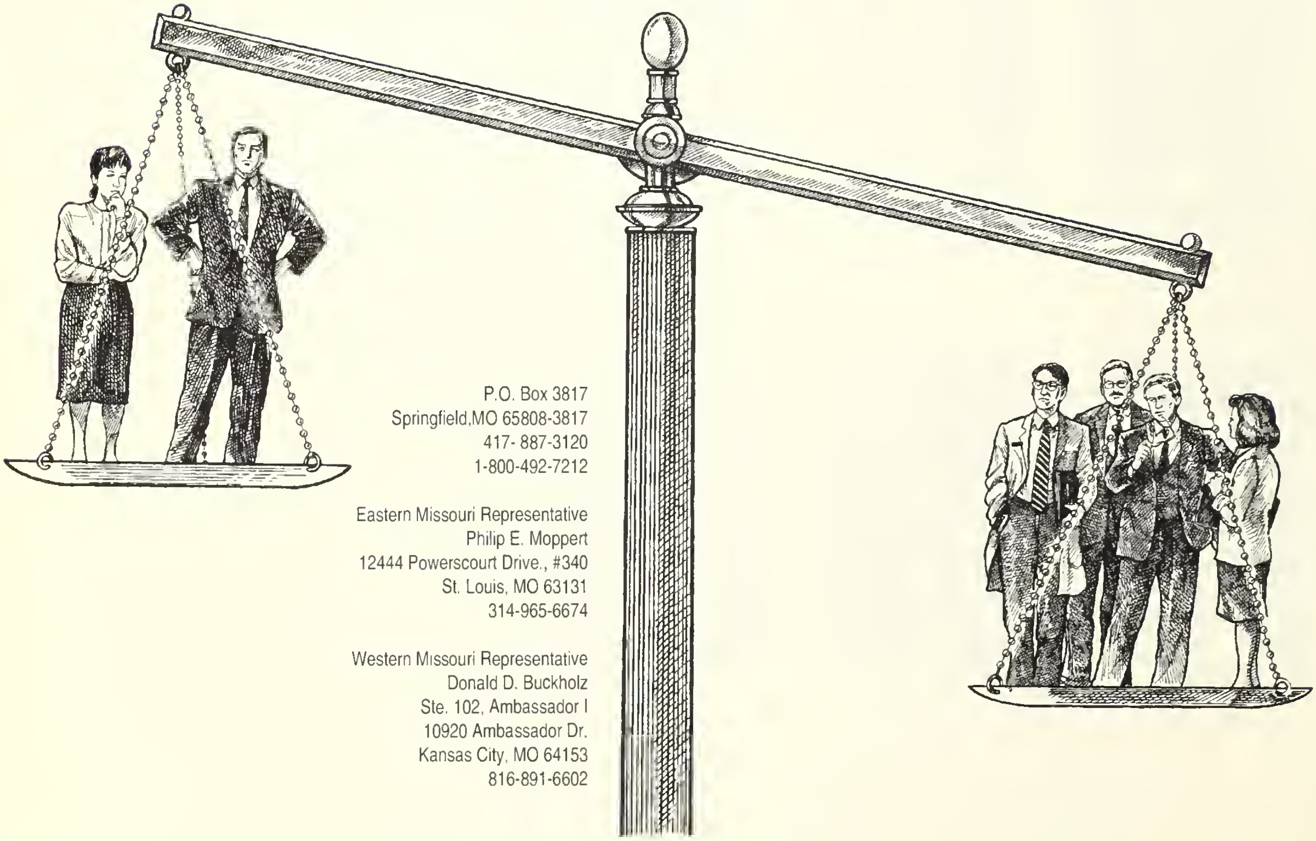

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Code of Medical Ethics and Fundamental Elements of the Patient-Physician Relationship

from the Council on Ethical and Judicial Affairs of the American Medical Association

HISTORY. The Oath of Hippocrates, a brief statement of principles, has come down through history as a living statement of ideals to be cherished by the physician. This Oath was conceived some time during the period of Grecian greatness, probably in the fifth century B.C. It protected rights of the patient and appealed to the inner and finer instincts of the physician without imposing sanctions or penalties on him or her. Other civilizations subsequently developed written principles, but the Oath of Hippocrates (Christianized in the tenth or eleventh century A.D. to eliminate reference to pagan gods) has remained in Western Civilization as an expression of ideal conduct for the physician.

The most significant contribution to Western medical ethical history subsequent to Hippocrates was made by Thomas Percival, an English physician, philosopher, and writer. In 1803, he published his Code of edictal Ethics. His personality, his interest in sociological matters, and his close association with the Manchester Infirmary led to the preparation of a "scheme of professional conduct relative to hospitals and other charities" from which he drafted the code which bears his name.

At the first official meeting of the American Medical Association at Philadelphia in 1847, the two principal items of business were the establishment of a code of ethics and the creation of minimum requirements for medical education and training. Although the Medical Society of the State of New York and the Medico-Chirurgical Society of Baltimore had formal written codes of medical ethics prior to this time, it is clear the AMA's first adopted Code of Ethics was based on Percival's Code.

In general, the language and concepts of the original Code adopted by the Association in 1847 remained the same throughout the years. There were revisions, of course, which reflect the temper of the times and the eternal quest to express basic concepts with clarity. Major revisions did occur in 1903, 1912, and 1947.

In December 1955, an attempt was made to distinguish medical ethics from matters of etiquette. A draft of a two-part code seeking to accomplish this was submitted to the House of Delegates at that time but was not accepted. This proposal was, in effect, a separation of then existing statements found in the Principles into two categories. Little or no change was made in the language of the forty-eight sections of the Principles.

Subsequently, in June 1956, a seemingly radical proposal was submitted to the House of Delegates for consideration. This proposal, a short version of the Principles, was discussed at the December 1956 session of the House after wide publication and broad consideration among members of the medical profession. It was postponed for final consideration until the June of 1957 meeting of the House of Delegates, when the short version was adopted.

The format of the Principles adopted in June 1957 is a change from the format of the Principles promulgated by Percival in 1803 and accepted by the Association in 1847. Ten short sections, preceded by a preamble, " succinctly express the fundamental concepts embodied in the present (1955) Principles," according to the report of the Council on Constitution and Bylaws. That Council assured the House of Delegates in its June 1957 report that "every basic principle has been preserved; on the other hand, as much a possible of the prolixity and ambiguity which in the past obstructed ready explanation, practical codification in particular selection of basic concepts has been eliminated."

In 1977, the Judicial Council recommended to the House of Delegates that the AMA Principles of Medical Ethics be revised to clarify and update the language, to eliminate reference to gender, and to seek a proper and reasonable balance between professional standards and contemporary legal standards in our changing society. Given the desire of the Judicial Council for a new version of the Principles to be widely accepted and accurately understood, in 1978 the Judicial Council recommended that a special committee of the House be appointed to consider such a revision. This was done in 1980, and the House of Delegates adopted the revision of the AMA Principles of Medical Ethics.

In June 1985, the Judicial Council became the Council on Ethical and Judicial Affairs.

PRINCIPLES OF MEDICAL ETHICS

Preamble:
The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standard of conduct which define the essentials of honorable behavior for the physician.

I.
A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II.
A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III.
A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV.
A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V.
A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI.
A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII.
A physician shall recognize a responsibility to participate in activities contributing to an improved community.

FUNDAMENTAL ELEMENTS OF THE PATIENT-PHYSICIAN RELATIONSHIP

From ancient times, physicians have recognized that the health and well-being of patients depends upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physicians in a mutually respectful alliance. Physicians can best contribute to this alliance by serving as their patients' advocate and by fostering these rights:

1.
The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their physicians might have, and to receive independent professional opinions.

2.
The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.

3.
The patient has the right of courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.

4
The patient has the right to confidentiality. The physician should not reveal confidential communications or information with out the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

5.
The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient sufficient opportunity to make alternative arrangements for care.

6.
The patient has a basic right to have available adequate health care. Physicians, along with the rest of society, should continue to work toward this goal. Fulfillment of this right is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay for the care. Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care.

Policies of the Association

Alcohol Abuse

The MSMA continues to support the work of community-based organizations such as AA, Al-Anon, Narcotics Anonymous, and others, and it reaffirms its support of professional and public education efforts designed to alert people to the dangers of alcohol and drug abuse. In addition, the MSMA continues to support the Physician Rehabilitation Program and similar programs aimed at helping the victims of alcohol and drug abuse to recover successfully. (1987)

Board of Healing Arts

The MSMA opposes any legislation that would dilute the licensing power of the State Board of Registration for the Healing Arts to license physicians of good ethical and moral character. (1975)

The MSMA encourages and supports legislation directed toward developing a system of checks and balances with regard to the Board of Registration for the Healing Arts' ability to both investigate and assess (tax) physicians. (1992)

Reporting of Cancer

The MSMA supports efforts to require hospitals to report to the state all malignant neoplasms, with the exception of non-melanomatous cutaneous malignancies. These statistical data are necessary to determine relationships between cancer control efforts and the incidence of cancer in the state. (1982)

Chelation Therapy

The MSMA supports the use of IV chelation therapy in FDA-approved applications only. (1990)

Chiropractic

The MSMA is unaware of any scientific evidence that proves that spinal manipulation and adjustment are appropriate treatments for such health conditions as hypertension, heart disease, stroke, cancer, diabetes, and infection. (1981)

Definition of Death

A person shall be considered dead if, in the announced opinion of a licensed physician, based on ordinary standards of medical practice, he has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person shall be considered dead if, in the announced opinion of a licensed physician, based on ordinary standards of medical practice, he has experienced a total and irreversible cessation of spontaneous brain functions, including the brain stem. Death shall have occurred at the time when the relevant functions ceased. (1987)

Ordering of Diagnostic Tests

With the exception of not-for-profit health fairs and mammography screening, the MSMA is opposed to, and considers unethical, the practice of ordering laboratory studies and other diagnostic tests without evidence or indication obtained by a physician in a history and physical examination. (1989; amended 1991)

Dioxin

The MSMA supports continuing monitoring of dioxin research, recognizing that to date no serious human disease has been conclusively linked to exposure to the chemical. The findings of the AMA Council on Scientific Affairs Panel on Toxic Substances are supported by the MSMA. (1985)

Disabled

The MSMA is involved in seeking positive ways to encourage training and rehabilitation for disabled persons. The MSMA wants to work with existing organizations to remove physical and emotional barriers that prevent people from working. (1982)

Drugs, Generic Prescribing

The MSMA opposes any interference into the practice of medicine by any governmental agency, third party payer, or commercial dispensing organization through mandated generic or therapeutic substitutions for physician prescriptions. (1992)

Drugs, Physician Dispensing

The MSMA supports the physician's right to dispense drugs and devices when it is in the best interest of the patient and consistent with the AMA's published ethical guidelines. (1988)

Continued on next page

The MSMA believes that dispensing of drugs and medical devices is part of the practice of medicine and that physicians always have the right to dispense needed drugs and devices. (1991)

Drugs, Therapeutic Substitution

The MSMA opposes the therapeutic substitution of prescribed medications. (1990)

Drunken Driving

The MSMA supports the development of local task forces to study and remedy the problem of drunken driving. These task forces should include physicians, prosecutors, law enforcement officers, and legislators. (1990)

Education, Loans for Medical Students

The MSMA supports continued federal and state subsidized, low-interest loan programs for medical students, with properly enforced repayment. (1982)

Education, School Health

Factual, academically founded courses should be developed and implemented by the Missouri Department of Education to teach human physiology and pathophysiology at the elementary and secondary levels of the school system. (1974)

County medical societies are urged to work with local school districts to assist in providing comprehensive health education programs, and the state colleges of Missouri are urged to prepare qualified health instructors trained to integrate health concepts into all the courses they teach. (1972)

Emergency Care

The MSMA supports the American College of Emergency Physicians and the American College of Surgeons standards for direct medical control of pre-hospital (emergency) care by qualified physicians. (1986)

Ethics, Education in Medical School

The MSMA supports the teaching of medical ethics to medical students and resident physicians, including information on the workings of professional disciplinary agencies. (1987)

Expert Witness Qualifications

The MSMA supports legislation to formalize required qualifications for physicians wishing to testify as expert witnesses.(1992)

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Fee-for-service Medicine

The MSMA believes that the traditional American fee-for-service medical system should be given equal consideration and equal treatment under the law as other systems of health care provision. (1990)

Fee Splitting

The MSMA reaffirms its support of the AMA Judicial Council's position that the acceptance of financial consideration in exchange for patient referrals, or fee splitting, is unethical and improper. (1985)

Fireworks

The MSMA supports legislation to prohibit the sale of Class C fireworks in the state of Missouri. (1991)

Fluoridation

The MSMA, realizing the medical importance of naturally occurring fluoride taken in proper concentration into the human body, recommends the addition of fluoride to all drinking water systems in Missouri in the concentration of one part per million. (1972)

Governmental Intrusion into Practice of Medicine

The MSMA opposes any further governmental intrusion into the practice of medicine, particularly in the form of rules and regulations from federal agencies. (1992)

Health Care Costs

The MSMA encourages individual physicians to do their part in helping moderate increases in health care costs by avoiding overutilization and by using restraint when considering fee increases, in order to keep them in line with general cost of practice increases. (1989)

Helmets, Use of

The MSMA urges all motorcyclists to wear protective head gear (helmets) to prevent death and disability. (1977)

The MSMA supports legislation requiring the use of bicycle safety helmets as an effective method of reducing death and injury. (1991)

Hospital Medical Staffs, Autonomy

Since the hospital medical staff is a largely autonomous entity within the hospital, the MSMA supports the securing of separate legal counsel by medical staff members when considering matters of rules, regulations and bylaws. (1985)

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Hospital Medical Staffs, Membership

The hospital medical staff cannot be forced to accept for full voting membership any member of the allied health professions. This is in keeping with the MSMA's support of existing JCAHO and AMA guidelines that state no hospital governing board can unilaterally amend the bylaws of a self-governing medical staff, nor can it unreasonably withhold approval of the bylaws. (1987)

The MSMA supports existing state statutes and regulations that delineate requirements for hospital licensure and individual eligibility for medical staff privileges. (1989)

Human Rights

The MSMA continues to support the dignity of the individual, the importance of human rights and the sanctity of human life, and continues to oppose any discrimination based on an individual's ethnic origin, religious or political beliefs, or any such reprehensible policies. (1986)

Immunization

The MSMA supports American Academy of Pediatrics guidelines for immunization of children. (1987)

Indigent Care

The MSMA urges all physicians to share in the care of indigent patients. (1988)

Insurance, Charge for Extra Claim Forms

Physicians should feel free to charge for the additional service of filing more than one insurance claims form for an individual patient, especially if different claim forms are required rather than a photocopy of the original form. (1973)

Insurance, Insurance Co. Communications

The MSMA urges health insurance companies to cease to communicate abusive and inappropriate language to patients regarding their physicians' fee structures and services. (1985)

Insurance, Maternity Coverage

The MSMA supports inclusion in all insurance policies for those in childbearing years of a clause providing complete maternity coverage.

In order to provide continuity of coverage, the following eligibility period should be written into all insurance policies concerning benefits for obstetric care: "A pregnancy which begins while the insurance is in force should be covered until the termination of the puerperium and until the newborn infant is discharged from the hospital to home care." (1974)

Insurance, New Waiting Periods

The MSMA believes employees should not have to undergo a new waiting period for coverage of pre-existing illness whenever their employer changes insurance companies, particularly when the change is being made in the interest of controlling health care coverage costs. (1985)

Insurance, Psychiatric Illnesses

The MSMA recommends that the state require all health and accident insurance policies sold in Missouri to provide coverage for psychiatric illnesses equivalent to benefits for other medical and physical illnesses. (1978) Reaffirmed (1985)

Insurance, Right to Know

The MSMA encourages all third party payors to provide an easily understood explanation of their benefits and coverage to their policyholders. (1986)

International Medical Graduates

The MSMA Council and committees are encouraged to consult with International Medical Graduate groups when subjects of interest come up. All physicians, international medical graduates included, are encouraged to participate in their component medical societies, the MSMA, and the AMA. (1982)

Laboratory, Collecting Fee

The MSMA supports payment under Medicaid to the physician for his service in collecting a specimen for tests performed in an outside laboratory. (1977)

Licensing, Federal

The MSMA opposes any moves to require federal licensure of health manpower. (1976)

Malpractice, Countersuits

Any Missouri physician found not to be negligent in a malpractice suit shall have the assistance of the MSMA in determining if there exists a reasonable basis for the physician to commence an action for malicious prosecution arising out of such case. (1976)

Mandated Second Opinion

The MSMA suggests that the physician who renders a mandated second opinion for a proposed surgical procedure not accept that person as a patient for the proposed surgical procedure. (1987)

Mandatory Assignment

The MSMA is opposed to mandatory assignment under Medicare. (1984)

The MSMA is opposed to the withholding of medical licensure based on the physician's non-acceptance of Medicare assignment. (1987)

Medical Examiner System

The establishment of a county medical examiner system as a replacement for the county coroner system is strongly recommended. (1971)

Medicare-Mandated Restrictions

The MSMA opposes Medicare-mandated restrictions on any laboratory tests, referrals, medical examinations or any financial arrangements that might be agreed upon between physician and patient. (1988)

Medicare - DRGs for Physician Reimbursement

The MSMA opposes the use of Diagnosis-Related Groups as a system of reimbursing physicians under the Medicare program. (1992)

Medicare - Reimbursement to Starting Physicians

The MSMA believes starting physicians should not be reimbursed at a lower rate than other physicians. All physicians should be reimbursed equally for equal services. (1992)

Medicare - Single Statewide Payment Factor

The MSMA supports the adoption by the Health Care Financing Administration of a single, statewide geographic Medicare physician payment adjustment factor for the state of Missouri. (1992)

Medicare - Third Party Reimbursement, Physicians

The MSMA supports equal reimbursement for equal professional services provided by a physician, regardless of his geographic location. (1982) Reaffirmed (1987)

Medicare - Reimbursement, Hospital DRGs

The MSMA believes it is unfair for Medicare to grant a lower payment to rural hospitals, as compared to urban hospitals, for patient care under the same DRG. (1988) Reaffirmed (1989)

Mentally Incompetent Patients, Hospitalization

The MSMA urges extension of the time limit from 7 to 21 days before the family of a mentally incompetent patient must petition the court for continuation of a hospitalization. (1985)

MSMF Loans

The Missouri State Medical Foundation requires membership in the state medical association for those medical students eligible for membership and receiving assistance from the Foundation. (1980)

Nurse Practitioners

The MSMA supports the doctrine that physicians should retain control of medical care and will challenge any person who is practicing medicine without a license, in the courts of law if necessary. (1978)

Patient Accountability

The MSMA encourages government, at all levels and whenever possible, to incorporate incentives for patients to behave in ways not detrimental to their health. (1992)

Peer Review Organization Data

The MSMA asks that data from the Missouri Patient Care Review Foundation concerning decision-making criteria for Medicare admission be made available to Missouri physicians as a way to ensure that denials are not having a negative impact on the quality of medical care for these patients. (1985)

The MSMA supports the current AMA program of data collection on the costs of PRO implementation and the inequities in the PRO system. (1987)

Peer Review Organization Review

The MSMA reaffirms its belief that physicians' work should be reviewed only by other physicians. In addition, the MSMA supports the modification of PRO standards of reviewer anonymity, believing that the reviewers' work should also be subject to review. (1990)

Physician as Patient Advocate

The MSMA affirms its support of the physician in the role of patient advocate in the consumption of health care services, particularly when this role conflicts with the economic goals of the physician's employing third party. (1987)

Physician Assistants

The MSMA opposes state licensure or certification of additional health care personnel because there is no reason to accept a second class or second level of medicine. (1979)

Physician, Right to Choose

The MSMA supports the right of each physician to determine for him or herself whom he or she will or will not accept as patients and to exercise his or her choice by the terms of contractual agreements with other physicians, medical groups, third party payers, governmental agencies, hospitals or other institutions. (1981; updated 1992)

Physician, Right to Hospital Privileges

The MSMA is opposed to the granting of hospital privileges to a physician based on that physician's profitability to the hospital. (1988)

Political Process

The Association encourages physicians to become Key Contacts, thereby increasing medicine's role in influencing actions taken by the Missouri General Assembly on issues of importance to our patients and our profession. (1983)

Primary Medical Care

Primary medical care shall be defined as only that care given by a licensed graduate of a medical or osteopathic school. (1977)

Referral to Licensed Limited Practitioner

A physician may refer a patient for diagnostic or therapeutic services to another physician, licensed limited practitioner, or any other licensed provider of health care services whenever the physician feels that these services will benefit the patient. As is the case with physician referrals, limited practitioner referrals should be based on the practitioner's individual competence and ability to perform service to the patient.(1981)

Registered Dietitians

The MSMA supports the concept that any person using the title "dietitian" should be a Registered Dietitian. (1987)

Health Care Decision-making, Right to Refuse Treatment

Believing that critical decisions should be left to the patient, the family, or health care surrogate, and not to the state, the MSMA opposes any legislation that would require court approval for the withdrawal of life support systems, including artifical hydration and nutrition. The MSMA opposes legislation that would impose an arbitrary waiting period before such life support could be withdrawn. (1990)

Health Care Decision-making, Surrogate Decision-maker

The MSMA supports legislation allowing competent Missourians to appoint a health care surrogate, empowered by the patient to make medical decisions for him if he be unable. Such authority should include the power to accept or refuse any and all medical treatment for the patient, including artificial nutrition and hydration. (1990)

Smoking

The MSMA supports legislation directed at designating non-smoking areas in public places, and prohibits smoking at all MSMA House of Delegates meetings and scientific sessions held in conjunction with these meetings. (1981)

The MSMA actively supports legislation prohibiting cigarette smoking in public indoor areas. (1983)

School Bus Safety

The MSMA endorses special pre-licensing examination and investigation of prospective school bus drivers in Missouri, according to criteria established by law. (1986)

Utilization Review, Reimbursement

In those hospitals that conduct utilization review of any inpatient care, compensation of physicians for such review is a legitimate expense. The cost of such review should be included in hospital rates and reimbursable costs regardless of the source of payment. (1976)

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Constitution & Bylaws

(adopted 1903, revised April 1993)

CONSTITUTION

Article I. Name of the Association

The name and title of this organization shall be the Missouri State Medical Association.

Article II. Mission

The Mission of the Missouri State Medical Association is to serve its members through promotion of the science and art of medicine, protection of the health of the public, and betterment of the medical profession in Missouri.

Article III. Membership

Membership in this Association shall be limited to and include all members in good standing in component societies which hold charters from this Association.

Article IV. House of Delegates

The House of Delegates shall be the legislative body of this Association and shall consist of delegates elected by the component societies as well as all Past-Presidents of the Association, the Speaker and Vice-Speaker and the Deans of each medical school located in Missouri who are members of the Missouri State Medical Association, who shall serve as Delegates-at-Large. Its Secretary shall be the Secretary of the Missouri State Medical Association.

Article V. Council

The Council shall be the executive body of this Association when the House of Delegates is not in session. It shall consist of the President, President-Elect, Immediate Past President, Secretary, and Treasurer, the duly elected Councilors from each Councilor District and the duly elected Councilors from the Medical Student Section, the Resident Physicians Section, and the Hospital Medical Staff Section. A majority of voting members of the Council shall constitute a quorum.

Article VI. Council on Ethical and Judicial Affairs

The Council on Ethical and Judicial Affairs shall be the judicial body of the Association. It shall consist of five active members nominated by the President and elected by the House of Delegates.

Article VII. Sessions & Meetings

Section 1. The Association shall hold an annual Spring Convention of the House of Delegates, at places fixed by the House of Delegates, the time of which shall be fixed by the Council. During the Annual Convention, the House shall hold at least three sessions.

Section 2. Special meetings of the Association or the House of Delegates may be called by a two-thirds vote of the Council and shall be called upon a petition signed by members equal in number to one-third of the total number of delegates certified for the last Annual Convention.

Article VIII. Officers

Section 1. The Officers of this Association shall be a President, a President-Elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and a Vice-Speaker of the House of Delegates, and Councilors selected as provided for.

Section 2. The Officers shall be elected annually. The term of Councilors and Vice-Councilors shall be two years, except for the duly elected medical student Councilor, resident physician Councilor and hospital medical staff Councilor, who shall each be elected for a one-year term. Half of the membership of the Council shall be elected each year. The delegates from each Councilor District shall meet prior to the last day of the Annual Convention and elect the Councilors and Vice-Councilor from that district. The Delegates from the Medical Student Section, the Resident Physicians Section and the Hospital Medical Staff Section shall meet prior to the last day of the Annual Convention and elect their respective Councilor. In the event of death, resignation or removal of any Councilor, the Vice-Councilor shall automatically fill the vacancy. The Officers shall serve until their successors are elected and installed.

Article IX. Funds, Expenses and Budget

Funds shall be raised by a per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised in any other manner approved by the House of Delegates. The Council shall submit an annual budget to the House of Delegates. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

Article X. Referendum

At any General Meeting of the Association, it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Association for its vote. A majority vote of all members of the association shall determine the question.

Petitions signed by 10 percent of the active members of the Association, including petitioners representing at least one-half of the component medical societies, will initiate a referendum regarding changes in the Constitution and Bylaws or questions before the House of Delegates. A two-thirds vote of all active members of the Association responding will determine the question.

Article XI. Seal

The Association shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

Article XII. Amendments

The House of Delegates may amend any article of the constitution by a two-thirds vote of the delegates present and voting in any Annual Convention, provided that such amendment shall have been presented in the previous open meeting of the House of Delegates and that the amendment shall have been published twice during the year in the Journal of the Association or sent officially to each component society at least two months prior to the meeting at which final action is to be taken.

BYLAWS

Chapter I. Membership

Section 1. Members of this Association shall be those individuals whose names have been certified by secretaries of component societies to the Secretary of this Association that they are duly elected members of a component society and are legally qualified physicians practicing in Missouri, except as otherwise provided. Each member must be of good moral and professional standing, and must not support, nor practice, nor claim to practice any exclusive system of medicine.

Section 2. No person who is under sentence of suspension or expulsion from any component society of this Association or whose name has been dropped from its roll of members shall be entitled to any of the rights or benefits of this Association.

Section 3. There shall be five classes of members as follows:

Active members shall be limited to those members of component societies who (1) hold the degree of Doctor of Medicine or Bachelor of Medicine, and (2) if permitted by the bylaws of the component society, members who hold the degree of Doctor of Osteopathy, and (3) are entitled to exercise the rights of active membership in their component societies, as determined by their component societies, subject to the provisions of these Bylaws.

Resident members shall be limited to those members of the Resident Physicians Section who are serving a full-time postgraduate training program in a hospital approved by the American Medical Association and shall enjoy all of the privileges of active membership.

Student members shall be limited to those members of the Medical Student Section who are pursuing a course of study leading to the degree of Doctor of Medicine in a medical school approved by the American Medical Association and shall enjoy all of the privileges of active membership.

Honor members shall be limited to Honor members of component societies, which societies have requested that active members who have reached advanced years and have long served the Association and the profession be made Honor members of the Association. They shall enjoy all the privileges of active membership and shall be exempt from the payment of dues.

Special Dues-Exempt members shall be limited to those members of component societies who have been elected to the U.S. Congress, the Missouri State Legislature, or to an office in the executive branch of the state or federal government. They shall be exempt from the payment of dues until the term of their political office expires, and shall enjoy all the privileges of active membership.

Chapter II. General Meetings

Section 1. The General Meetings shall be open to all registered members and guests.

Section 2. Any paper read before this Association shall be considered for publication in the Journal if the author so desires. Such papers may be given publication priority over regularly submitted papers but shall be subject to the same editorial review and selection policies.

Section 3. No person in the active practice of medicine in the State of Missouri shall appear on the program of the Association unless he or she is a member of the Missouri State Medical Association or sponsored by a member. In the latter situation, the paper would be considered that presented by a member.

Chapter III. House of Delegates

Section 1. The House of Delegates shall meet annually at the time and place of the Annual Convention.

All resolutions received at the association office no later than 45 days prior to the opening session of the Annual Convention will be accepted as business of the House of Delegates and will be published in the Delegates Handbook. Any additional resolutions to be introduced at the opening session must be made available to each member of the House of Delegates at least 24 hours before the opening session. These will be accepted as business of the House at the opening session and will be referred to an appropriate Reference Committee. Resolutions introduced at the opening session, but which did not meet the 24-hour deadline, will be referred to a Reference Committee only if approved by two-thirds of the Delegates voting. Sufficient copies of the resolution, printed in standardized format, or funding for same, must be supplied by the individual or society introducing the resolution.

At the second session of the House of Delegates, introduction of Resolutions would be allowed only if approved by two-thirds of the delegates voting. The same procedure with regard to resolutions would be followed at the last session, but it would then take a unanimous vote of the House to allow such introduction. At the discretion of the Speaker, these conditions would not apply for resolutions of good wishes, condolences, congratulations and others of a personal nature.

Section 2. Delegates to the House of Delegates shall be allotted according to the following formula:

(a). Each component society shall be entitled to send each year one delegate or one alternate for each 25 full paid members or fraction thereof in the Association as of December 31 of the previous year.

(b). One additional delegate or alternate is allowed for each 100 members or major fraction thereof as of December 31 of the previous year.

(c). When a component society's full paid membership as of December 31 of the previous year reaches 1,000, that society shall be entitled to an additional 30 delegates or alternates.

(d). When a component society's full paid membership as of December 31 of the previous year reaches 2,000, that society shall be entitled to an additional 50 delegates or alternates.

(e). Each component society which is composed of two or more counties shall be entitled to at least one delegate from each of the counties having one or more member physicians practicing in the county of which the component society is composed; however, such delegates from multicounty component societies must practice or reside in the county they represent. Alternate delegates may be elected from the entire membership of the component medical societies.

(f). All Past-Presidents of the association, the Speaker and Vice-Speaker, and the deans of each medical school located in Missouri who are members of the Missouri State Medical Association shall serve as Delegates-at-Large.

(g). Only duly elected delegates have the privilege of the floor at meetings of the House of Delegates. However, any delegate may request the privilege of the floor for any other individual, which privilege may be granted or denied by the Speaker, subject to disapproval by a majority vote of the House of Delegates.

Section 3. Each Medical School Component Society shall be entitled to send each year two delegates, elected by the component society, to represent the Medical Student Section in the House of Delegates at the Annual Convention. Each delegate shall be a member in good standing with this Association and the component society. Such student delegates shall enjoy all the rights and privileges of all other delegates.

Section 4. The Resident Physicians Section shall be entitled to send each year six delegates elected by the Section to the House of Delegates at the Annual Convention. Each delegate shall be a member in good standing with this Association. Such resident delegates shall enjoy all rights and privileges of all other delegates.

Section 5. The Hospital Medical Staff Section shall be entitled to send each year one delegate elected by the Section to the House of Delegates at the Annual Convention. Each delegate shall be a member in good standing with this Association and the Section. Such delegates shall enjoy all rights and privileges of all other delegates.

Section 6. Forty delegates shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the association.

Section 7. From among members of the House of Delegates, the Speaker shall appoint reference committees to which reports and resolutions, on a majority vote of the House of Delegates, shall be referred as follows:

Reference Committee A
Reference Committee B
Reference Committee C
Reference Committee D
Reference Committee E

The Speaker may appoint such other reference committees as he may deem necessary, upon approval of the House of Delegates.

The President shall appoint a Committee on Credentials.

Section 8. The House of Delegates shall elect delegates and alternates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 9. The House of Delegates shall divide the state into Councilor Districts, specifying which counties each district shall include and, when the best interest of the Association and the profession will be promoted thereby, organize in each a district medical society of which all members of the component societies shall be members.

Section 10. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates. Such committees shall report to the House of Delegates and may be present and participate in the debate on their reports.

Section 11. The House of Delegates shall receive and act upon a complete detailed annual audit of receipts and expenses of the preceding year and a proposed budget for the current calendar year which shall have been prepared by the Council and submitted to the component societies at least four weeks prior to the Annual Convention. These shall be published in the Journal.

Section 12. The following shall be the general order of business of the House of Delegates for the first session of the Convention.

1. Call to order by the Speaker.
2. Report of the Committee on Credentials.
3. Roll Call.
4. Reading and adoption of minutes.
5. Report of officers.
6. Report of committees.
7. Unfinished business.
8. New business.

The following shall be the general order of business of the House of Delegates for the last session of the Convention.

1. Call to order by the Speaker.
2. Report of the Committee on Credentials.
3. Roll Call.
4. Reading and adoption of minutes.
5. Election of officers.
6. Reports of officers.
7. Reports of committees.
8. Unfinished business.
9. New business (Chap. III, Sec. 1).
10. Installation of officers.
11. President's appointments and installation of members to committees.
12. Selection of the place for the next Annual Convention.

At any session of the House of Delegates, the order of business may be changed by a two-thirds affirmative vote of the members present and voting.

Chapter IV. Election of Officers

Section 1. The President, on the first day of the Annual Convention, shall select a Committee on Nominations consisting of thirteen delegates, one from each Councilor District, one from the Medical Student Section, one from the Hospital Medical Staff Section and one from the Resident Physicians Section.

The Committee on Nominations shall determine that proposed candidates for office are qualified and willing to serve and shall report at the Second Session to the House of Delegates in the form of a ticket containing the names of one or more members for each of the officers listed in Article VIII of the Constitution, which are to be filled at the Annual Convention, excepting the Secretary and Treasurer, who are elected by the Council from the general membership.

Section 2. All contested elections shall be by written ballot. A majority of the votes cast shall be necessary to elect.

Delegates and Alternates for the American Medical Association shall be elected as follows:

The Nominating Committee shall propose one or more candidates for each delegate position for a full two-year term, one or more candidates for each alternate position for a full two-year term, and one or more names for each unexpired position.

When a nomination for AMA delegate term is contested, the AMA delegates shall be elected by ballot. Each MSMA delegate may have one vote for each delegate to be elected and each vote shall be cast for a different nominee. A nominee is elected if he receives votes on the majority of the ballots cast, and has the highest number of votes cast for that position. If all vacancies for AMA delegates are not filled on the first ballot, then subsequent ballots will be taken with the nominee receiving the fewest number of votes cast in each subsequent ballot dropping out of consideration on the next ballot and each MSMA delegate casting one vote for each position in each subsequent ballot until one nominee for each position is elected.

The election for AMA alternates and an election to fill an unexpired term will be conducted in the same manner.

In case no nominee for general offices of the Association (see Article VIII, Constitution) receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected.

Section 3. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Section 4. Delegates present at the Annual Convention from Councilor Districts whose Councilors' and Vice-Councilor's terms expire shall hold meetings on or before the morning of the last day of the Annual Convention and elect Councilors and a Vice-Councilor for their district for a term of two years. The names of the elected Councilors and Vice-Councilors shall be given on prescribed forms to the Secretary for presentation to the House of Delegates. Each candidate for Councilor or Vice-Councilor must reside or practice in the district for which he is elected.

Section 5. Each Councilor District shall be entitled to one Councilor for each 400 full paid members or portion thereof and full paid members of the Resident Physicians Section training in that Councilor District as of December 31 of the preceding year. Each District shall be entitled to one Vice-Councilor.

Section 6. Delegates from the Medical Student Section shall combine and elect one Councilor and one Vice-Councilor. The duly elected Councilor and Vice-Councilor from the medical student component societies shall serve on an annual renewable basis.

Section 7. Delegates from the Resident Physicians Section shall combine and elect one Councilor and one Vice-Councilor. The duly elected Councilor and Vice-Councilor from the Resident Physicians Section shall serve on an annual renewable basis.

Section 8. The Hospital Medical Staff Section shall combine and elect one Councilor and one Vice-Councilor. The duly elected Councilor and Vice-Councilor from the Hospital Medical Staff Section shall serve on an annual renewable basis.

Section 9. The Speaker and Vice-Speaker shall not serve more than three consecutive terms.

Section 10. The Speaker shall appoint a parliamentarian to serve as such during the sessions of the House of Delegates at each Annual Convention and upon whom the Speaker may call before deciding points of order or procedure.

Chapter V. Duties of Officers

Section 1. The **President**, or his designated representative, shall preside at scientific sessions of the Association. He shall preside at the House of Delegates in the absence of the Speaker or Vice-Speaker and until their successors are elected. He shall appoint all committees not otherwise provided for. He shall deliver an annual address at such times as may be arranged and shall perform such other duties as custom or parliamentary usage requires. He shall be the real head of the profession of the state and assist the Councilors in building up the component societies and in making their work more practical and useful.

Section 2. The **President** and the **President-Elect** shall be members of the Council and shall attend all meetings of the Council. The President-Elect shall assume the office of the President at the Annual Convention following his election to the position of President-Elect. Should the office of President-Elect become vacant through death or otherwise, the Council may fill the vacancy by appointment until the next Annual Convention.

Section 3. The **Vice-Presidents** shall assist the President in the discharge of his duties. Prior to the meeting of the Nominating Committee, the President-Elect shall recommend to the Nominating Committee the name of a member to serve as First Vice-President. In the event of the death, resignation, or removal of the President, the First Vice-President shall serve as President for the unexpired term.

Section 4. The **Treasurer** shall give bond in the sum of $50,000. He shall demand and receive all funds due the Association, together with bequests and donations. Money shall be paid out of the treasury only on the written order of the President and Executive Vice-President, the President and Treasurer, or the Treasurer and Executive Vice-President. The Treasurer shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his actions and of the state of the funds in his hands.

Section 5. The **Secretary** shall attend the General Meeting of the Association and the sessions of the House of Delegates, and shall keep minutes of their respective proceedings in separate record books. He shall be Secretary of the Council and shall keep a record of its proceedings. He shall be the custodian of all record books and papers belonging to the Association, except such as properly belong to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Association that come into his hands. He shall provide for the registration of the members and delegates at the Annual Convention. He shall, with the cooperation of the secretaries of the component societies, keep a register of all the legal practitioners of the state by counties, noting on each his status in relation to his component society,and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their reports and shall collect from them the regular per capita dues and assessments and turn the same over to the Treasurer.

Chapter VI. Council

Section 1. The Council shall meet during the Annual Convention and at such times as necessity may require, subject to the call of the Chairman or on petition of three Councilors. It shall meet on the last day of the Annual Convention to organize. The Council shall elect a Chairman and a Vice-Chairman for a term of one year. The Chairman may be reelected to serve not more than four consecutive terms of one year each. The Council shall, through its Chairman, make an annual report to the House of Delegates.

Section 2. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exists, for inquiring into the condition of the profession, and to keep in touch with the activities of and aid in the betterment of the component societies of his district. He shall make reports of his work and the condition of the profession of each county in his district to the Council. The necessary traveling expenses incurred by each Councilor in the line of duties herein imposed may be allowed on a properly itemized statement submitted monthly and within the current year, including his expense in attending the Annual Convention of the Association. No Councilor shall be eligible for the position of Delegate to the House of Delegates during his term of office as councilor, nor shall he vote in the House of Delegates.

Section 3. The Council shall be the executive body of the Association and between the Annual Conventions shall exercise the power conferred on it by the House of Delegates under the Constitution and Bylaws.

Section 4. Charters shall be issued to component societies only on approval of the Council and shall be signed by the President and Secretary of this Association. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 5. In sparsely settled sections, the Council shall have authority to organize the members of two or more counties into societies, to be suitably designed so as to distinguish them from district societies. These societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 6. The Council shall provide for and supervise the issuance of all publications of the Association including proceedings, the transactions and memoirs, and shall have authority to appoint an Editor and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee of three of its members, to be known as a Committee on Auditing and Appropriations, shall audit all accounts of this Association. The Council shall adopt an annual budget providing for the necessary expenses of the Association for the following calendar year. This budget shall be prepared and presented for consideration in the last quarter of each year by the Committee on Auditing and Appropriations. A complete and detailed report shall be submitted to the component societies as provided in Chapter III, Section 11. The Council shall submit an annual report to the House of Delegates which shall specify the character and cost of the publications of the Association, the amount and character of all its property, and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

Section 7. The Council shall appoint, at least six months prior to the Annual Convention, a committee consisting of three of its members to be known as the Committee on Arrangements for the Annual Convention. On recommendation of the Committee, the Council shall appoint a Chairman of a Local Committee on Arrangements, who shall be a member of the component society of the county in which the Annual Convention is to be held, and who shall appoint and organize from the members of the component society the personnel of the Local Committee on Arrangements. The Local Committee on Arrangements shall serve as host for the Annual Convention and shall also act in an advisory capacity for the staff of the Executive Vice-President of the Association, who is responsible for arrangements for the Annual Convention.

Section 8. The Council shall by appointment fill any vacancy in office not otherwise provided for which may occur during the interval between Annual Conventions of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

Section 9. The salaries of all employees of the Association shall be fixed by the Council.

Section 10. The Council shall provide such headquarters for the Association as may be required to conduct its business properly.

Section 11. The Council shall be empowered to elect an Executive Vice-President and such other personnel as may be necessary, who need not be members of the Missouri State Medical Association, each of whom shall perform such duties as the Council may designate and receive such salary and serve for such periods and under such conditions as the Council may determine.

Chapter VII. Committees and Commissions

Section 1. Standing Committees of the Missouri State Medical Association, the chairmen of which shall be appointed by the Association President unless otherwise provided in these Bylaws, will be as follows:

Executive Committee.
Committee on Constitution and Bylaws.
Committee on Publication.
Committee on Legislative Affairs.
Committee on Planning.
Physicians Health Committee.
Young Physicians Committee

The **Executive Committee** shall consist of the Association President, the Immediate Past President, President-Elect, First Vice President, Secretary, Treasurer, Council Chairman and Council Vice-Chairman. The President of the Association shall be Chairman of the Executive Committee. The Executive Committee shall plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Vice-President's Office between meetings of the Council, but shall be responsible at all times to the Council.

The Committee on **Constitution and Bylaws** shall consist of five members named by the President and shall propose such amendments to the Constitution and Bylaws as are deemed wise and expedient and bring before the House of Delegates such amendments as it or other members of the Association may present for consideration. The President shall appoint one member for one year, two members for two years and two members for three years. As the term of each expires, his successor shall be appointed for a term of three years.

The Committee on **Publication** shall consist of five members and be appointed annually by the Council and shall be responsible for general publication and distribution policies of the Journal. The editor of the Journal shall be designated by the Council and also shall serve as Chairman of the Committee on Publication. The Editor shall be empowered to nominate an Editorial Board, subject to approval by the Council. The members of the Editorial Board will assist the Editor in soliciting, preparing and reviewing material for publication in the Journal.

The Committee on **Legislative Affairs** shall consist of five members of the Association, appointed annually by the President. The Committee shall consider legislative proposals affecting health problems of the people of the state and the practice of medicine and shall make recommendations to the Council and the House of Delegates as well as directing staff activities in such matters.

The **Planning Committee** shall consist of ten members to be appointed by the President. Two members shall be appointed for one year, two for two years, two for three years, two for four years and two for five years. As the term of each expires, his successor shall be appointed for a term of five years. In making such appointments, the President shall be governed by experience of the member, the size of his medical society and his geographical area, so as to have a representative committee. Age of the members shall be considered to the end that one-third to one-half of the committee shall be of an age group that should contemplate ten to twenty years more of active practice.

The **Physicians Health Committee** shall consist of members of the Association appointed by the President for a term of three years.The Physicians Health Committee shall plan and execute programs of professional assistance for members of this Association who may require assistance to continue or return to their professional activities.

The **Young Physicians Committee** shall consist of members of the Association appointed by the President for a term of three years. The Young Physicians Committee shall act as a vehicle for increasing the involvement of young physicians in the membership activities of the Missouri State Medical Association.

Section 2. Standing Commissions of the Missouri State Medical Association, who shall be responsible to the Council and whose chairmen shall be appointed by the Association President, will be as follows:

Commission on Public Affairs.
Commission on Medical Economics,
  Third Party Medicine
  and Governmental Relations.
Commission on Continuing Education
  and Health Manpower.
Commission on Medical-Legal Affairs.
Commission on Interspecialty Medicine.

Subsec. a. The standing commissions, unless otherwise provided in these Bylaws, shall consist of fifteen members serving three-year terms and the terms will be staggered so that the President will appoint five members of each Commission each year. Initially, the President will appoint five members to one-year terms, five members to two-year terms and five members to three-year terms and no member shall serve more than two consecutive terms.

Subsec. b. The chairman of each Commission may appoint Ad Hoc Committees to carry out the Commission's programs. These Ad Hoc committees may include any Missouri State Medical Association member.

Subsec. c. The Chairman of the Council shall appoint each year an appropriate Councilor to serve as advisor to each respective Commission.

The Commission on **Public Affairs** shall plan and execute programs designed to enhance the relationship between the public and the medical profession. The Commission shall have responsibility in the fields of industrial health, environmental health, medicine and religion, trauma, disaster medical care and national defense and other public matters.

The Commission on **Medical Economics, Third Party Medicine and Governmental Relations** shall keep close liaison and work with peer and utilization review mechanisms, insurance intermediaries and governmental agencies.

The Commission on **Continuing Education and Health Manpower** shall determine the character and scope of the scientific proceedings of the Association for each Annual Convention as well as to make all arrangements for such Annual Convention, subject to the instructions of the House of Delegates. The Commission shall also be responsible for the entire continuing education program of the Association, shall have all matters pertaining to hospitals referred to it, shall carry on all programs in the recruitment of health manpower in professional as well as in allied health fields and shall be responsible for programs in the rural health field.

The Commission on **Medical-Legal Affairs** shall investigate and study medical-legal matters affecting the practice of medicine, make recommendations to the Council and House of Delegates and also make certain that all Association members are kept informed of important developments in this field. The Commission also may work with similar groups formed by the State Bar Association on matters of joint interest and concern as well as with governmental and insurance agencies in this field.

The Commission on **Interspecialty Medicine** shall be composed of one representative of each statewide specialty group as recognized by the Association Council. The President of the Missouri State Medical Association shall appoint annually to the Commission a representative from each of the authorized groups as submitted to him by the specialty organization. In the event that such a nominee is not submitted to him by an organization, the Association President may designate a member of the specialty group to serve on the Commission.

The Commission shall be charged with the responsibility of reviewing organization problems with respect to scientific programs, socioeconomic and legislative matters that affect their particular specialties; in addition, the Commission shall have the responsibility for programs and activities in fields relating to disease and health services involving the citizens of our state and such other matters as the Council shall direct. Also, the Commission shall provide close liaison between the various specialty organizations and the Missouri State Medical Association.

Section 3. Fifty percent of a Committee or a Commission should be present at an official meeting to constitute a quorum.

Section 4. Special committees may be appointed by the President or the Council as circumstances may demand.

Chapter VIII. Medical Student Section

Section 1. Membership. Membership in the section shall be limited to Missouri State Medical Association members who are also students at an accredited medical school in the state of Missouri. The Section shall be the unifying body for the four independent Medical School Component Societies in the state.

Section 2. Governing Council. There shall be a Governing Council of the Medical Student Section to direct the programs and activities of the section, subject to the approval of the MSMA Council.

Section 3. Members of the Governing Council. There shall be five voting members of the Governing Council, consisting of the officers, the Student Councilor and the Student Vice-Councilor.

(a). Officers. The officers of the section shall have the following duties and responsibilities:

(b). Chairman. The Chairman shall preside at the business meetings of the section and at meetings of the Governing Council.

(c). Vice Chairman. The Vice Chairman shall assist the Chairman and preside in the absence of the Chairman or at his/her request.

(d). Secretary-Treasurer. The Secretary-Treasurer shall maintain such records and accounts as may be necessary or advisable for the conduct of the activities of the section.

(e). Councilor and Vice-Councilor. The Councilor and Vice-Councilor shall be elected by the members of his or her Medical School Component Society. The following sequence shall be used in determining the Medical School Component Society from which the Councilor and Vice-Councilor shall be elected on an annual rotating basis: Washington University, St. Louis University, the University of Missouri-Kansas City, the University of Missouri-Columbia.

(f). Delegates. Each Medical School Component Society shall elect two Delegates to represent the Medical Student Section in the MSMA House of Delegates.

Section 4. Term. Governing Council members, including the Councilor and Vice-Councilor shall serve one-year terms, beginning at the conclusion of the Annual Convention at which they were elected.

Section 5. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next business meeting of the Section.

Section 6. Section Meeting. There shall be a meeting of members of the section held prior to each Annual Meeting of the MSMA House of Delegates.

Section 7. Representatives to the Section Meeting. The annual meeting of the Section shall be open to any member of the Medical Student Section.

Section 8. Purpose of the Business Meeting. The purpose of the business meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To consider and vote upon such matters as may properly come before the meeting.

(c). To adopt resolutions for submission by the section to the House of Delegates of the MSMA.

(d). To elect a Chairman, Vice Chairman, and Secretary-Treasurer.

(e). To conduct such other business as may properly come before the meeting.

Chapter IX. Hospital Medical Staff Section

Section 1. Membership. Membership in the section shall be limited to Missouri State Medical Association members who are also members of a hospital medical staff in a Missouri hospital, and who are selected by the physician members of their respective medical staffs.

Section 2. Governing Council. There shall be a Governing Council of the Hospital Medical Staff Section to direct the programs and activities of the section, subject to the approval of the MSMA Council.

Section 3. Members. There shall be five voting members of the Governing Council, consisting of the officers, delegate and alternate delegate, elected at the business meeting of the section.

(a). Officers. The officers of the section shall have the following duties and responsibilities:

(b). Chairman. The Chairman shall preside at the business meetings of the section and at meetings of the Governing Council.

(c). Vice Chairman. The Vice Chairman shall assist the Chairman and preside in the absence of the Chairman or at his/her request.

(d). Secretary-Treasurer. The Secretary-Treasurer shall maintain such records and accounts as may be necessary or advisable for the conduct of the activities of the section.

(e). Delegate and Alternate Delegate. The Delegate and Alternate Delegate shall represent the members of the section in the MSMA House of Delegates.

Section 4. Term. Governing Council members, including the Delegates and Alternate Delegate, shall serve two-year terms, beginning at the conclusion of the Annual Convention at which they were elected.

Section 5. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next business meeting of the Section.

Section 6. Business Meeting. There shall be a business meeting of members of the section held prior to each Annual Meeting of the House of Delegates.

Section 7. Representatives to the Business Meeting. The physician members of the medical staff of each hospital may select a representative to the business meeting of the Hospital Medical Staff Section. The representative must be an MSMA member who is an active voting member of the medical staff with clinical privileges at the hospital.

Representatives to the business meeting shall be elected by and from the active voting members of the medical staff of each hospital.

Representatives to the business meeting shall be properly certified by the President or Secretary of the medical staff.

Only duly selected representatives to the Hospital Medical Staff Section shall have the right to vote at the business meeting of the section, but the meeting shall be open to any member of the MSMA. The meeting shall be conducted pursuant to rules of procedure adopted by the Governing Council of the section and approved by the MSMA Council.

Section 8. Purposes of the Business Meeting. The purpose of the business meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To consider and vote upon such matters as may properly come before the meeting.

(c). To adopt resolutions for submission by the section to the House of Delegates of the MSMA.

(d). To elect at the business meeting prior to the Annual Convention of the MSMA House of Delegates a Chairman, Vice Chairman, Secretary-Treasurer, Delegate and Alternate Delegate.

(e). To conduct such other business as may properly come before the meeting.

Chapter X. Resident Physicians Section

Section 1. Membership. The Resident Physicians Section shall be composed of Resident Members of the Missouri State Medical Association who are serving in approved training programs.

(a). Governing Council. There shall be a Governing Council for the Resident Physicians Section. The Governing Council shall consist of the officers of the Resident Physicians Section and two members-at-large of the Section. All members of the Governing Council must be Resident Physician members of the Missouri State Medical Association elected by the members attending the Business Meeting of the Resident Physicians Section.

1. Duties. The Governing Council shall direct the programs and the activities of the Resident Physicians Section.

2. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next Business Meeting of the Resident Physicians Section.

Section 2. Officers. The Members attending the Business Meeting of the Resident Physicians Section shall elect the following officers, who shall have these duties and responsibilities:

(a). Chairman. The Chairman shall preside at all meetings of the Governing Council and the Business Meetings of the Resident Physicians Section.

(b). Vice Chairman. The Vice Chairman shall preside at meetings of the Governing Council or the Business Meetings of the Resident Physicians Section, in the absence of the Chairman or at the request of the Chairman.

(c). Secretary. The Secretary shall maintain such records as are required or advisable for the conduct of the activities of the Resident Physician Section.

(d). Delegates and Alternate Delegates. The Delegates and Alternate Delegates shall represent the Section in the MSMA House of Delegates.

Section 3. Business Meeting. There shall be a Business Meeting of members of the Resident Physicians Section. The Business Meeting shall be held on a day prior to each Annual Meeting of the House of Delegates.

Section 4. Rules of Order. Only members of the Resident Physicians Section shall have the right to vote, but the meetings shall be open to any members of the Missouri State Medical Association. The meeting shall be conducted pursuant to established rules of procedure adopted by the Governing Council.

Section 5. Purposes of the Meeting. The Purpose of the meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To elect a Chairman, who shall serve until the conclusion of the next Annual Meeting.

(c). To elect other officers of the Resident Physicians Section and two members-at-large of the Governing Council. Those elected shall assume office at the conclusion of the Annual Meeting at which they are elected and shall serve until the conclusion of the next Annual Meeting.

(d). To consider and vote upon such matters as may properly come before the meeting.

Chapter XI. Dues and Assessments

Section 1. (a). The annual dues of this Association shall be $300, which shall be applicable to each active member of the Association beginning in 1987 and shall be levied per capita on the active members of the component societies; physicians leaving training programs and entering practice for the first time shall be assessed dues of $150 for the first calendar year and shall be Active members; physicians entering their second year of practice shall be assessed dues of $225 for the calendar year and shall be Active members; the per capita levy for resident members shall be $20 per year; student members shall be assessed dues of $5 per year; honor members shall not be required to pay dues. Dues shall be payable on January 1 of the year for which they are levied. Those members who join after July 1 of any given year shall be assessed at one-half of their regular dues rate, outlined in this section, for the calendar year in which they join.

Section 2. Three dollars of the annual dues shall be credited to the account of the Journal for each member's annual subscription. The remainder of the amount shall be credited to the general fund of the Association.

Section 3. The House of Delegates may, when in its judgment the best interest of the Association demands, recommend an assessment on each active, resident and student member. Such assessment shall be levied only by consent of two-thirds of the members of the House of Delegates present and voting. Funds obtained from such special assessment shall be allocated only for the purposes for which such assessment is levied and in accordance with substantiating budgets. Unexpended balances from such assessments must be reported to the House of Delegates for reallocation.

Section 4. The Secretary of each component society shall cause to be collected and remitted to the Treasurer of this Association the per capita levies. Upon authorization of any component society, the Treasurer of this Association may collect the per capita levies directly from the members of that component society. Any member whose name has not been reported for enrollment and whose dues have not been remitted to the Treasurer of this Association on or before March 1 shall stand suspended until his name is properly reported and his dues for the current year are paid. On December 31 of each year, members delinquent in payment of dues, and assessment if such has been made, or any part thereof shall, ipso facto, forfeit their memberships. No suspended member shall be eligible to register at an Annual Convention.

Chapter XII. Rules of Conduct

Section 1. The ethical principle governing the members of the American Medical Association shall govern members of this Association.

Section 2. Any member of this Association who testifies as a medical expert witness outside of the specialty of the physician represents unethical conduct. In the future, any physician who testifies as a medical expert witness outside of his specialty or logical extension of his field of expertise or who interferes with the proper administration of justice by misrepresenting his qualifications or giving false or misleading testimony will be subject to expulsion, censorship, or reprimand after due process from the Missouri State Medical Association.

Any member of this Association who testifies as a medical expert witness without meeting the qualifications set forth in this section, shall be subject to expulsion, censorship, or reprimand after a due process hearing as set forth. An expert witness must have basic educational and professional knowledge as a general foundation for his testimony and, in addition, have current personal experience and practical familiarity with the problems being considered and be actively engaged in the practice of the medical subject under discussion.

Nothing in the above is to be construed as preventing the treating physician from testifying on the merits of the case.

Chapter XIII. Rules of Order

The deliberations of this Association shall be conducted in accordance with usages as defined in *Davis' Rules of Order.*

Chapter XIV. Component Societies

Section 1. All component societies now in affiliation with the State Association or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Association provided that their Constitutions and Bylaws shall have been submitted to the Council and received its approval.

Section 2. Each component society shall be judge of the qualifications of its members, subject to review and final decision by the Council on Ethical and Judicial Affairs of the State Association. Every reputable and legally qualified physician or medical student who does not practice, nor profess to practice sectarian medicine, and who resides or practices in the same county, who shall apply for membership on the prescribed form and subscribe for the Journal and pay the annual dues and assessments for the current year, shall be eligible for election to membership.

A member of a component society whose license has been revoked shall be dropped from membership automatically as of the date of revocation. The Council on Ethical and Judicial Affairs of the State Association shall have final authority to expel a member should a component society fail to do so after being so requested by the Council on Ethical and Judicial Affairs.

The Council, may upon request of a component society, remit the state dues and assessment of a member who has become totally and permanently incapacitated through mental or physical disability and has been a member in good standing during the three consecutive years immediately preceding his disability; provided that the component society shall remit the component society dues of such member.

The Council may, upon request of a component society, remit the state dues and assessments of a deserving member found to fall within what is classified as a hardship case, during the period of said hardship until such time as the dues again become payable; provided that the component society shall remit the component society dues of such member.

A physician living near a component society boundary line may hold his membership in that component society most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

Section 3. Any member who may feel aggrieved by the action of the component society in suspending or expelling him shall have the right to appeal to the Council on Ethical and Judicial Affairs, whose decision shall be final. A component society shall at all times be permitted to appeal or refer questions involving membership to the Council on Ethical and Judicial Affairs of the State Association for final determination.

Section 4. In hearing appeals, the Council on Ethical and Judicial Affairs may admit oral or written evidence or both as in its judgment will most fairly present the facts.

Section 5. When a member in good standing in a component society moves to another jurisdiction in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the jurisdiction to which he moves. Pending his acceptance or rejection by the component society to which he moves, such member shall be considered to be in good standing in the component society from which he was certified and in the State Association to the end of the period for which his dues have been paid.

A member of a component society who moves to and engages in the practice of medicine at a location in another area in which there is a component society shall forfeit his membership in this Association and the Secretary shall remove his name from the roster of members of the Missouri State Medical Association unless within one year after such change of residence he becomes a member of the component society of the area to which he has moved.

Section 6. Each component society shall have general direction of the affairs of the profession in its area and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician and medical student in the area. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician and medical student in the area.

Section 7. At some meeting in advance of the Annual Convention of this Association, each component society, the Hospital Medical Staff Section, the Medical Student Section and the Resident Physicians Section shall elect one or more delegates and an equal number of alternates to represent it in the House of Delegates of this Association, in accordance with Chapter III, Section 2, 3, 4, or 5 of these Bylaws. The Secretary of each component society, the Hospital Medical Staff Section, the Medical Student Section and the Resident Physicians Section shall send a list of such delegates and alternates to the Secretary of this Association at least sixty days before the Annual Convention. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

Section 8. The secretary of each component society shall keep a roster of its members and, if practicable, a list of non-affiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary by the Council. He shall send a copy of the program of each meeting to his district Councilor and to the Secretary of the State Association.

Section 9. Any component society, in a manner approved by the State Association, or the State Association with the consent of the component society affected, may undertake, organize and put into effect plans for the medical care of indigent persons or indigent groups, and low-income groups, by agreements with physicians, public officials or others and by the use of contributions, cooperative funds or other means; provided, however, that a free choice of the available and participating physicians in that territory shall be allowed to the patient and that all relationships shall be and remain as though it were strictly an individual employment.

Chapter XV. Council on Ethical and Judicial Affairs

Section 1. The Council on Ethical and Judicial Affairs shall have original jurisdiction in all questions involving Missouri State Medical Association membership, all controversies arising under the Constitution and Bylaws and under the rules of conduct as outlined in the Bylaws, and controversies between two or more component societies or their members. The Council on Ethical and Judicial Affairs shall be the judicial authority of the Missouri State Medical Association and its decisions shall be final. The Council on Ethical and Judicial Affairs shall also investigate general ethical conditions and matters pertaining to the relations of physicians to one another or to the public and make recommendations to the House of Delegates or the component societies.

Section 2. The Council on Ethical and Judicial Affairs shall be composed of five members elected to five-year terms. Nominees shall be submitted by the President for election by the House of Delegates. Any vacancy occurring on the Council on Ethical and Judicial Affairs shall be filled by nomination of the President and election by the House at its next Convention for the remainder of the unexpired term. The first five members of the Council on Ethical and Judicial Affairs shall be elected on a staggered basis; one for one year, one for two years, one for three years, one for four years, and one for five years.

Section 3. The Council on Ethical and Judicial Affairs shall select a Chairman and Vice Chairman and it may adopt such rules and regulations as it deems necessary and appropriate for the conduct of its affairs, subject to approval by the MSMA Council.

Chapter XVI. Amendments

Section 1. These Bylaws may be amended at any Annual Convention by a two-thirds vote of the delegates present and voting at that session, if the proposed amendment has been properly submitted to the House of Delegates and has lain on the table for one day.

Section 2. Upon the adoption of this Constitution and these Bylaws, all previous constitutions and bylaws are thereby repealed.

Chapter XVII. Mission

The Mission of the Missouri State Medical Association is to serve its members through promotion of the science and art of medicine, protection of the health of the public, and betterment of the medical profession in Missouri.

SuperPAC 1993

Edgar I. Ailor, *Columbia*
David O. Barbe, *Mountain Grove*
Harry O. Cole, *St. Louis*
Mr. Royal O. Cooper, *Jefferson City*
H. Peter Ekern, *Mexico*
Robert T. Gibbons, Jr., *Overland Park, Kan.*
Frederick W. Hahn, Jr., *Independence*
Jerry D. Kennett, *Columbia*
Melvin C. Kasten, *Cape Girardeau*
Carl R. Kruse, *Palmyra*
Keith LaFerriere, *Springfield*
Mrs. Sandra Mitchell, *Kansas City*
R. William Morris, *St. Louis*
H. Jerry Murrell, *Columbia*
Mrs. Beverly Murrell, *Columbia*
David E. Perkins, *Chesterfield*
Mrs. Marge Perkins, *Chesterfield*
Frederick D. Peterson, *St. Louis*
Robert O. Schaaf, *Gower*
Hugh E. Stephenson, Jr., *Columbia*
Kirby L. Turner, *Poplar Bluff*
David Wilkinson, *St. Louis*
Carol F. Williams, *St. Louis*

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Edgar I. Ailor, *Columbia*
William C. Allen, *Columbia*
Willard M. Allen, *Glenwood Md.*
Kerry K. Assil, *St. Louis*
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Directory of Medical Specialty Organizations

Specialty	President	For Information
Missouri State Allergy Association	Jay M. Portnoy, MD Children's Mercy Hospital, 24th&GillhamRd. Kansas City, MO 64108 (816)234-3097	Contact the President.
Greater Kansas City Allergy Association	Jeffrey A. Wald, MD Suite 200, 4500 College Blvd. Shawnee Mission, KS 66211 (913)491-5501	Contact the President.
Missouri Society of Anesthesiologists	Stephen McCray, MD P.O. Box 7391 N. Kansas City, MO (816)346-7000	Contact the President.
Greater Kansas City Society of Anesthesiologists	Gregory K. Unruh, MD University of Kansas Medical Center Dept. of Anesthesiology 3901 Rainbow Blvd. Kansas City, KS 64160 (913)588-6670	Contact the President.
St. Louis Society of Anesthesiologists	Sidney J. Bennett, MD	Contact: James M. Shear, MD, Secretary 1 Barnes Hospital Plaza, Box 8054 St. Louis, MO 63110 (314)362-2327
St. Louis Cardiac Club	Alan J. Tiefenbrunn, MD	Contact: Thomas F. Martin, MD, Secretary 2120 Madison Ave, Suite 401. Granite City, IL 62040 (618)876-2700
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Crohn's & Colitis Foundation of America	Teri Pollard, RPH	Contact Saundra Johnson 8900 State Line, Suite 354 Leawood, KS 66206 (913)648-7738
Kansas City Dermatologic Society	David L. Kaplan, MD Suite 116, 4601 W. 109th St. Overland Park, KS 66211 (913)469-1115	Contact the President.
St. Louis Dermatological Society	Robert E. Ziegler, MD	Contact: David B. Marrs, MD, Vice President 330 First Capitol Drive, Suite 460 St. Charles, MO 63301 (314)946-7608
The St. Louis Ear, Nose and Throat Club	Gerald W. Moritz, MD	Contact: Stanley E. Thawley, MD, Secretary 4911 Barnes Hospital Plaza St. Louis, MO 63110 (314)362-7524
Missouri Chapter, American College of Emergency Physicians	Michael Szewczyk, MD 910 West Broadway Columbia, MO 64068 (314)875-3501	Contact the President.
Emergency Physicians Medicine Foundation	Mark Steele, MD Truman Medical Center Dept. of Emergency Medicine 2301 Holmes Kansas City, MO 64108 (816)556-3569	Contact the President.
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Kansas City Academy of Family Practice	Rose Zwerenz Truman Medical Center Dept of Family Practice Kansas City, MO 64139 (816)373-4415	Contact the President.

St. Louis Academy of Family Physicians	Gary P. Lessmann, MD	Contact: Mary E. Fox, MD, Secretary 2900 Lemay Ferry Rd., Suite 224 St. Louis, MO (314)487-7277
St. Louis Gastrointestinal Endoscopy Society	Burton A. Schatz, MD	Contact:John J. Kelly, MD, Sec.-Tres. 226 South Woods Mill Rd. Chesterfield, MO 63017 (314)432-1111
Kansas City Gynecological Society	Gerald L. Miller, Jr., MD Suite T301, 6420 Prospect Kansas City, MO 64132 (816)444-6888	Write or call: Suite 205, 7920 Ward Parkway Kansas City, MO 64114 (816)523-3383
St. Louis Gynecological Society	William Houck, MD	Contact: Tamara Ostapowicz 12810 Teason Ferry Rd. St. Louis, MO 63128 (314)849-3711
Missouri Society of Internal Medicine	David Fleming, MD 1513 Union St. Moberly, MO 65270 (816)263-4040	Contact the President.
St. Louis Society of Internal Medicine	Benjamin A. Borowsky, MD	Contact: Leon R. Robinson, MD, Sec.-Tres. 222 S. Woods Mill Rd., Suite 750 N Chesterfield, MO 63017 (314)576-6770
Greater Kansas City Society of Internists	Bruce E. Johnson, MD University of Kansas Medical Center Department of Internal Medicine Kansas City, KS 66160 (816)588-5000	Write or call: Suite 205, 7920 Ward Parkway Kansas City, MO 64114 (816)523-3383
Missouri Chapter, American College of International Physicians	Ramesh Khanna, MD 2514 Ridgefield Rd. Columbia, MO 65203 (314)882-7991	Contact the President.
Missouri State Neurological Association	William J. Crowley Jr, MD	Contact: Lee Gibson 111B East Walnut Columbia, MO 65203 (314)874-8985
Kansas City Neurology & Neuro Surgery Society	Gregory Horning, MD Suite 328, 4320 Wornall Rd. Kansas City, MO (816)931-1150	Contact the President.
St. Louis Society for Neurological Sciences	Robert L. Grubb, MD	Contact: Camilo R. Gomez, MD, Sec.-Tres. 3635 Vista at Grand St. Louis, MO 63110 (314)577-8738
Missouri Section, American College of OB-GYN (ACOG)	Stephen Gordon, MD 930 Carondelet Dr., Suite 304 Kansas City, MO 64114 (816)943-2229	Contact President.
Great Plains College Occupational & Environmental Medicine	Michael J. Poppa, DO Suite 255, 600 Broadway Kansas City, MO 64105	Write or call: Suite 205, 7920 Ward Parkway Kansas City, MO 64114 (816)523-3383
St. Louis Society of Medical Oncology	Alex E. Denes, MD	Contact: James M. Schweitzer, MD, Sec.-Tres. 330 First Capitol Drive St. Charles, MO 63301 (314)947-4007
Missouri Ophthalmological Society, Inc.	Stephen Slocum, MD 1034 S. Brentwood, #694 St. Louis, MO 63117 (314)721-8250	Contact the President
Kansas City Society of Ophthalmology & Otolaryngology	David D. Braverman, MD Suite 302, 4601 W. 109th St. Shawnee Mission, KS 66211	Contact Metro Med of Kansas City 3036 Gillham Rd. Kansas City, MO 64108 (816)531-8432
St. Louis Ophthalmological Society	Robert C. Drews, MD	Contact: R. Joseph Olk, MD One Barnes Hospital Plaza, Suite 17413 St. Louis, MO 63110 (314)367-1181

Missouri State Orthopaedic Association	Thomas R. Highland, MD Columbia Spine Ctr, 400 Keene St. POBox0 Columbia, MO 65205 (314)443-2402	Contact the President.
Kansas City Orthopaedic Society	Robert Takacs, MD Suite 103, 6650 Troost Kansas City, MO 64131 (816)444-4664	Contact the President.
St. Louis Orthopedic Society	James C. Strickland, MD	Kenneth W. Zehnder, MD 6400 Clayton Rd., Suite 302 St. Louis, MO 63117 (314)647-8562
Jackson County Osteopathic Society	G. Donald Stillie, DO P.O. Box 22608 Kansas City, MO 64113 (816)751-2930	Write or call: 400 E. Red Bridge Rd., Suite 105 Kansas City, MO 64131 (816)942-6063
Missouri Society of Otolaryngology - Head & Neck Surgery	Frederick Hahn, MD 4801 Cliff Ave., #204 Independence, MO 64055 (816)478-3555	Contact the President.
Missouri Society of Pathologists	Arteso C. Raborar, MD 5650 Woodcliff Springfield, MO 65084 (417)882-2900	Contact: William Dorzab, MD, President-elect Menorah Medical Center, 4949 Rockhill Rd Kansas City, MO 64110 (816)276-8262
Mid-Missouri Pathology Society	No President.	Contact: Mitchell Rosenoltz, MD MU School of Medicine - Dept. of Pathology Columbia, MO 65212 (314)882-1228
Kansas City Society of Pathologists	John C. Overman, MD Office of the Medical Examiner 2301 Holmes Rd. Kansas City, MO 64108 (816)283-3553	Contact the President.
St. Louis Pathological Society	Christine M. Janney, MD	Contact: Wagth A. Bari, MD, Sec.-Tres. 615 S. New Ballas Rd. St. Louis, MO 63141 (314)569-6120
Missouri Chapter, American Academy of Pediatrics	Robert Edmonds, MD	Contact: Lee Gibson 111B East Walnut Columbia, MO 65203 (314)874-8985
Greater Kansas City Pediatric Society	Michael A. Blum, DO Suite 200, 401 Clairborne Olathe, KS (913)764-7060	Write or call: Metro Med of Kansas City 3036 Gillham Rd. Kansas City, MO 64108 (816)756-1132
St. Louis Pediatric Society	Allison Nash, MD	Contact: Alan Friedman, MD, Sec.-Tres. 1465 S. Grand St. Louis, MO 63104 (314)577-5369
Physical Medicine and Rehabilitation	Henry Stonnington, MD 501 Rusk Rehabilitation, 1 Hospital Drive Columbia, MO 65212 (314)882-3101	Contact the President.
St. Louis Society of Physical Medicine & Rehabilitation	Martin B. Wice, MD	Contact: Daniel G. Sohn, MD, Sec.-Tres. 615 S. New Ballas Rd. St. Louis, MO 63141 (314)569-6436
Missouri Association of Plastic & Reconstructive Surgeons	William B. Webber, MD 6400 Clayton #110 St. Louis, MO 63117 (314)645-6051	Contact the President.
Plastic Surgery Society of Kansas City	Thomas E. Geraghty, MD Suite 204, 4444 N. Bellevue Kansas City, MO 64116 (816)455-3062	Write or call: Metro Med of Kansas City 3036 Gillham Rd. Kansas City, MO 64108 (816)531-8432
St. Louis Area Society of Plastic Surgery	Meredith J. Payne, MD	Contact: Charles D. Ettelson, MD, Secretary 222 S. Woods Mill Rd. Chesterfield, MO 63017 (314)878-7770

Eastern Missouri Psychiatric Society	Lori DeRosear, DO	Contact: Wilson M. Compton III, MD, Sec. 4940 Children's Place St. Louis, MO 63110 (314)362-2465
Central Missouri Psychiatric Society	Enrique DoSantos, MD	Contact: Lee Gibson 111B East Walnut Columbia, MO 65203 (314)874-8985
Western Missouri Psychiatric Society	Sherman W. Cole, MD Suite 114, 6400 Prospect Kansas City, MO 64132 (816)363-5554	Write or call: Metro Med of Kansas City 3036 Gillham Rd. Kansas City, MO 64108 (816)531-8432
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Greater Kansas City Radiological Society	C. H. Jospeh Chang, MD University of Kansas Medical Center Dept. of Radiology, 3901 Rainbow Blvd. Kansas City, KS 66160 (913)588-6807	Contact the President.
Greater St. Louis Society of Radiologists	Thomas E. Reh, MD	Contact: V. Rao Dovineni, MD, Sec.-Tres. 12303 DePaul Dr. Bridgeton, MO 63044 (314)344-6090
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Missouri Chapter, American College of Surgeons	Gregorio A. Sicard, MD	Contact: Linda Wheelen P.O. Box 4562 Springfield, MO 65808 (417)869-5222
Missouri State Surgical Society	Joseph Corrado, MD 809 Medical Park Drive, #103 Mexico, MO 65265	Contact: Ron Ellison 113 Madison, PO Box 1028 Jefferson City, MO 65102 (314) 636-5151
Kansas City Surgical Society	Richard T. Padulah, MD. Suite T211, 6420 Prospect Kansas City, MO 64132 (816)523-8120	Write or call: 24th & Gillham Rd. Kansas City, MO 64108 (816)234-3893
St. Louis Surgical Society	Virginia Hermann, MD	Contact: John P. Hoehn III, MD, Secretary 621 S. New Ballas Rd., C-598 St. Louis, MO 63141 (314)569-6656
Missouri Thoracic Society	Carlos Daughaday, MD	Dennis R. Pyszcynski, MD UMKC School of Medicine, 2411 Holmes St. Kansas City, MO 63108 (816)235-1978
St. Louis Thoracic Surgical Society	John P. Marbarger, MD	Contact: Keith S. Naunheim, MD, Sec.-Tres. 3635 Vista Ave. at Grand St. Louis, MO 63110 (314)577-8360
Missouri Urological Society	Michael Chehval, MD 621 S. New Ballas Rd., #6002 St. Louis, MO 63141 (314)991-2626	Contact the President.
Kansas City Urological Society	Mark Noble, MD University of Kansas Medical Center 39th & Rainbow Blvd. Kansas City, MO 66103 (913)588-6148	Contact the President.
St. Louis Urological Society	David Hardy, MD	Contact: Thomas F. Scully, MD, Sec.-Tres. 911 S. Brentwood Blvd. St. Louis, MO 63105 (314)645-6454
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Personal Disability Income. Benefits available up to $10,000. Life-time accident/to age 65 sickness coverage. Residual disability benefit available with cost of living increase provision. An individual contract with special renewal guarantees.	Commercial Insurance Company of Newark, N.J.	Sedgwick James 2420 Pershing Rd. Suite 220 Kansas City, MO 64108 (816)842-6670
Overhead Expense Insurance. Benefits up to $15,000. Optional 15-day or 30-day waiting periods after which payment begins from first day of disability and continues up to 2 years.	Commercial Insurance Company of Newark, N.J.	Sedgwick James (See above)
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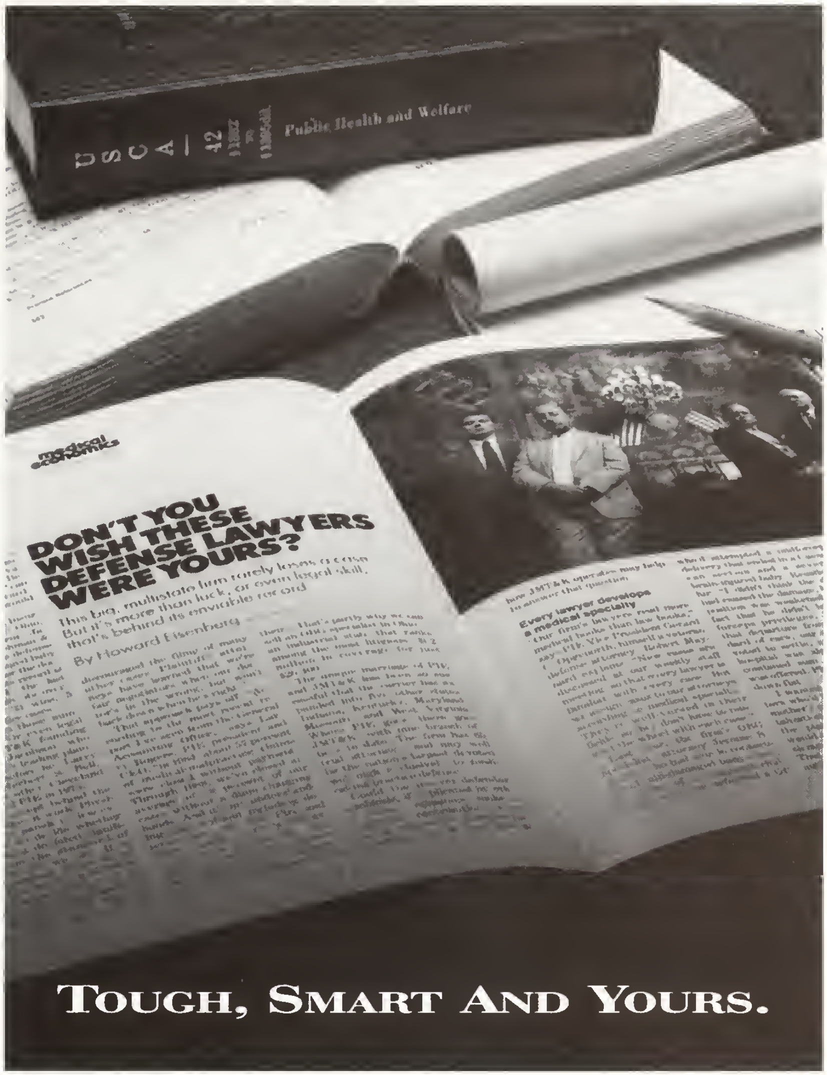
Hospital indemnity Plan. $50 to $200 per day while hospitalized in addition to any other insurance. Family coverage available.	Commercial Insurance Company of Newark, N.J.	Sedgwick James (See above)
Individual Noncancelable Products. Personal, Office, Overhead, Buy/Sell products. Benefits available to members at a 15% discount.	UNUM Life Insurance Company, Portland, ME	Sedgwick James (See above
Term Life Plan. Members and employees under age 60 may enroll for amounts up to $250,000. Spouses coverage, one half amount of member or employee, up to $100,000. Dependent children may be insured for $2,500.	Continental Casualty Company	Forrest T. Jones and Co., Inc. 3130 Broadway P.O. Box 418131 Kansas City, MO 64141 1-800-821-7303
Accidental Death/Dismemberment. $25,000 guaranteed up to $100,000.	Continental Casualty Company	Forrest T. Jones and Co., Inc. (See Above)
Major Medical Plan. Pays up to a lifetime of $1,000,000. Deductibles of $200, $500, $1,000. Coverage available to members, employees, and dependents, with survivor benefits. Extremely low cost policy.	Continental Casualty Company	Forrest T. Jones and Co., Inc. (See Above)
The Dodson Plan. The Dodson Plan gives participating physicians the opportunity to receive yearly dividends on their workers' compensation premium, depending on claim costs and related expenses.	Casualty Reciprocal Exchange, Member of Dodson Group	Dodson Group 9201 State Line Road Kansas City, MO 64114 1-800-825-3760
Retirement and Financial Planning. Retirement and Financial Planning services including investment advice, plan administration and IRS approved prototype plan documents. Financial planning including estate, retirement, investment, income tax and insurance analysis.	MonetaMed, A Moneta Group Program	Moneta Group, Inc. 700 Corporate Park Drive Suite 300 St. Louis, MO 63105 1-800-833-1301 in St. Louis, (314)726-2300



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MSMA Component Societies Executives or Secretaries

Andrew County Medical Society
J.L. Villahermosa, M.D., Sec.
803 Highway 71 West
Savannah, MO 64485
(816)324-3121

Audrian County Medical Society
Harry B. Cohen, M.D., Sec.
P.O. Box 598
Mexico, MO 65265
(314)581-2059

B-W-R-C County Medical Society
Carolyn Depriest, Exec. Sec.
P.O. Box 3986
Poplar Bluff, MO 63901
314/686-3171

Barton County Medical Society
Thomas W. Carroll, M.D., Sec.
1204 Gulf Street
Lamar, MO 64759
(417)682-5584

Boone (Cooper-Howard) County Medical Society
Lee Gibson, Exec. Director
111-B East Walnut
Columbia, MO 65203
314/874-8985

Buchanan County Medical Society
Patty Moore, Exec. Sec.
801 Faraon
St. Joseph, MO 64501
816/271-7517

C-M-M-R County Medical Society
Robert V. Tompson, M.D., Sec.
RR 4, Box 200 T
Moberly, MO 65270
(816)263-6045

Callaway County Medical Society
Vernon Jackson, M.D., Sec.
808 Center St., #202
Fulton, MO 65251

Cape Girardeau County Area Medical Society
Lois Kasten, Exec. Director
1005 N. Kingshighway
Cape Girardeau, MO 63701
314/334-5691

Clay-Platte Medical Society
Darren Frerking, Exec. Director
3036 Gillham Road
Kansas City, MO 64108
816/531-8432

Clinton County Medical Society
Larry Ozenburger, M.D., Sec.
400 Clay
Plattsburg, MO 64477

Cole (Moniteau-Osage) County Medical Society
Lee Gibson, Exec. Director
111-B East Walnut
Columbia, MO 65203
314/874-8985

D-H-P-D County Medical Society
J. Gustavo Nix, , M.D., Sec.
1125 North Butterfield Rd.
Bolivar, MO 65613
(417)887-1017

Dunklin County Medical Society
Nicholas F. Robinson, M.D., Sec.
501 Teaco Road
Kennett, MO 63857
(314)888-6603

F-G-W County Medical Society
Philip Dean, M.D., Sec.
800 East 5th St.
Washington, MO 63090
(314)239-5444

Grand River Medical Society
Billy Howell, M.D., Sec.
125 E. Locklin
Brookfield, MO 64628
(816)258-7235

Greene County Medical Soceity
James Thompson, Jr., Exec. V.P.
1200 E. Woodhurst Bldg., D-200
Springfield, MO 65804
417/887-1017

Henry County Medical Society
Kenneth F. Scott, M.D., Sec.
Medical Building Hospital Drive
Clinton, MO 64096
(816)885-8141

Jasper County Medical Society
Judy Miller, Exec. Director
P.O. Box 2424
Joplin, MO 64803
(417)624-3920

Jefferson County Medical Society
Alfred D. Shaplin, M.D., Sec.
910 Kimswick Manor Lane
Ballwin, MO 63011
(314)933-1055

Johnson County Medical Society
Curtis Dyer, M.D., Sec.
222 E. Culton Street
Warrensburg, MO 64093
(816)747-5114

Lafayette-Ray County Medical Society
Robert R. Pavlu, M.D., Sec.
Waverly Clinic
Waverly, MO 64096
(816)493-2262

Lake of the Ozarks Medical Society
Melvin R. Haden, M.D., Sec.
P.O. Box 1140
Camdenton, MO 65020
(314))346-5624

Metropolitan Medical Society of Greater Kansas City
Ron Cosens, Exec. Director
3036 Gillham Road
Kansas City, MO 64108
816/531-8432

Mid-Missouri Medical Society
Pat Bass, Exec. Sec.
1501 E. Tenth St., Suite A
Rolla, MO 65401
(314)364-7799

Mineral Area Medical Society
J. David Auner, Exec. Sec.
401 W. Russell St.
Ironton, MO 63650
(314)546-3434

Montgomery County Medical Society
Sam J. Byland, M.D., Sec.
120 Hudson Street
Wellsville, MO 63384

North Central Medical Society
Milton English, M.D., Sec.
2902 North Baltimore
Kirksville, MO 63501
(816)665-9322

Northeast Missouri Medical Society
Steven Halpin, M.D., Sec.
711 Grand
Hannibal, MO
(314)221-5250

Northwest Missouri Medical Society
James Humphrey, M.D., Sec.
502 State Street
Mound City, MO 64470
(816)442-5464

Ozarks Medical Society
Paul Anderson, M.D., Sec.
113 West Hickory St.
Neosho, MO 64850
(417)451-1234

Pemiscot County Medical Society
Tracy Durham, Exec. Sec.
Hwy. 61 7 Reed, P.O. Box 489
Hayti, MO 63851

Perry-Ste. Genevieve Medical Society
David Kapp, M.D., Sec.
210 Hospital Lane
Perryville, MO 63775
(314)547-7888

Pettis County Medical Society
Rodney Hartman, M.D., Trea.
1735 Sycamore, Rt. 3
Sedalia, MO 65301
(816)826-0216

Pike County Medical Society
Edward A. Glenn, M.D., Sec.
211 South 3rd Street
Louisiana, MO 63353
(314)472-4440

St. Charles-Lincoln County Medical Society
Deonna Randall, Exec. Sec.
2850 West Clay -St. Charles Clinic
St. Charles, MO 63301
314/925-0411

St. Louis Metropolitan Medical Society
G.R. Garrett, Exec. V.P.
3839 Lindell Blvd.
St. Louis, MO 63108
314/371-5225

Saline County Medical Society
Mica Newman-Koehn, M.D., Sec.
370 S. Odell Ave.
Marshall, MO 65340
(816)886-3364

SEMO Medical Society
Ted Roberts, M.D., Sec.
1118 North Main Suite B
Sikeston, MO 63801
(314)472-4440

South Central Medical Society
Thomas R. Stubbs, M.D., Sec.
709 Kentucky
West Plains, MO 65775
(417-256-0056

Tri-Lakes Medical Society
Ernest Hall, Jr., M.D., Sec./Treas.
Highland Center
Hollister, MO 65672

Webster County Medical Society
Robert Bareis, M.D., Sec.
Rt. #1, Box 2645
Marshfield, MO 65706
(417)468-2339

West Central Medical Society
Raphael Torontow, M.D., Sec.
Rt. # 2
Nevada, MO 64772
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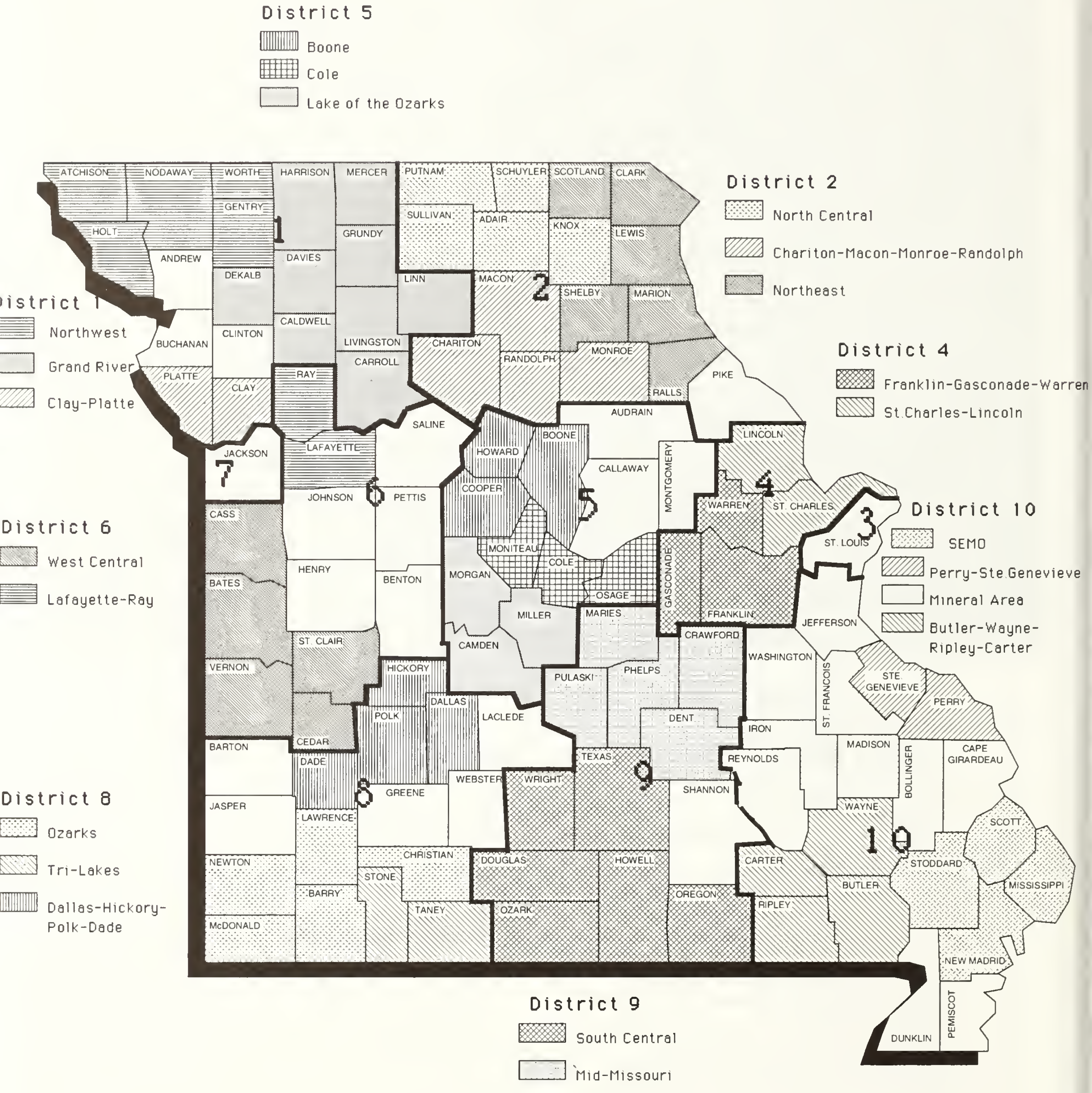
State Map with District & Component Society Boundaries


District 5
▥ Boone
▦ Cole
☐ Lake of the Ozarks
District 1
▤ Northwest
☐ Grand River
▨ Clay-Platte
District 2
☐ North Central
▨ Chariton-Macon-Monroe-Randolph
☐ Northeast
District 4
▦ Franklin-Gasconade-Warren
▧ St.Charles-Lincoln
District 10
☐ SEMO
▨ Perry-Ste.Genevieve
☐ Mineral Area
▧ Butler-Wayne-Ripley-Carter
District 6
☐ West Central
▤ Lafayette-Ray
District 8
☐ Ozarks
▧ Tri-Lakes
▥ Dallas-Hickory-Polk-Dade
District 9
▦ South Central
☐ Mid-Missouri
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10
ATCHISON
NODAWAY
WORTH
HARRISON
MERCER
PUTNAM
SCHUYLER
SCOTLAND
CLARK
GENTRY
HOLT
ANDREW
DAVIES
GRUNDY
SULLIVAN
ADAIR
KNOX
LEWIS
DEKALB
CALDWELL
LINN
MACON
SHELBY
MARION
BUCHANAN
CLINTON
LIVINGSTON
CARROLL
CHARITON
RANDOLPH
MONROE
RALLS
PIKE
PLATTE
CLAY
RAY
SALINE
AUDRAIN
LAFAYETTE
JACKSON
HOWARD
BOONE
CALLAWAY
MONTGOMERY
LINCOLN
JOHNSON
PETTIS
COOPER
WARREN
ST. CHARLES
ST. LOUIS
CASS
MONITEAU
COLE
HENRY
BENTON
MORGAN
OSAGE
GASCONADE
FRANKLIN
BATES
MILLER
MARIES
CRAWFORD
JEFFERSON
ST. CLAIR
CAMDEN
PULASKI
PHELPS
WASHINGTON
VERNON
HICKORY
ST. FRANCOIS
STE. GENEVIEVE
POLK
DALLAS
LACLEDE
DENT
PERRY
IRON
CEDAR
BARTON
DADE
TEXAS
REYNOLDS
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MSMA 1993-94 Directory

DISTRICT	COUNCILORS	MEDICAL SOCIETIES & Code numbers	COUNTIES
FIRST	Stephen Vilmer,M.D. Shawnee Mission, KS	Andrew (010), Buchanan (030), Clinton (054), Northwest (158) , Grand River (078), Clay-Platte (050)	Andrew, Atchison, Buchanan, Caldwell, Carroll, Clay, Clinton, Davies, DeKalb, Gentry, Grundy, Harrison, Holt, Linn, Livingston, Mercer, Nodaway, Platte, Worth
SECOND	Carl Kruse, M.D. Palmyra	Chariton-Macon-Monroe-Randolph (046), North Central (148), Northeast (150), Pike (186)	Aldair, Chariton, Clark, Knox, Lewis, Macon, Marion, Monroe, Pike, Putnam, Ralls, Randolph, Schyyler, Scotland, Shelby, Sullivan
THIRD	Gordon M. Goldman, M.D., St. Louis, Robert N. Miller, M.D., St. Louis, Arturo Montes, MD, Florissant, Daniel O'Sullivan, M.D., St. Louis, Meredith Payne, M.D., Chesterfield, Frederick D. Peterson, M.D., St. Louis	St. Louis Metropolitan (190)	St. Louis County and City
FOURTH	Sammy L. Farrell, M.D. Washington	Franklin-Gasconade-Warren (074), St. Charles-Lincoln (189)	Franklin, Gasconade, Lincoln, St. Charles, Warren
FIFTH	Jerry Kennett, M.D., Columbia, Robert Wankum, M.D., Jefferson City	Audrain (014), Boone (026) (includes Cooper-Howard), Callaway (038), Cole (058) (includes Moniteau-Osage), Lake of the Ozarks (120), Montgomery (146) ,	Audrain, Boone, Callaway, Camden, Cole, Cooper, Howard, Miller, Moniteau, Montigomery, Morgan, Osage
SIXTH	A.J. Campbell, M.D., Sedalia	Henry (086) Johnson (110), Lafayette-Ray (118), Pettis (178), Saline (198), West Central (214)	Bates, Benton(*), Cass, Cedar, Henry, Johnson, Lafayette, Pettis, Ray, St. Clair, Saline, Vernon
SEVENTH	Steven Buie, M.D., Lee's Summit, William Dorzab, M.D., Kansas City, Frederick W. Hahn, M.D., Independence, Robert T. Gibbons, Jr., M.D., Overland Park, KS	Metro Med - Greater Kansas City (125)	Kansas City and Jackson County
EIGHTH	David W. Hall, M.D., Rogersville Duane Hellam, M.D., Springfield	Barton(018), Dallas-Hickory-Polk-Dade (066), Greene (082), Jasper(102), Laclede (115), Ozarks (166), Tri-Lakes (208), Webster (210)	Barry, Barton, Christian, Dade, Dallas, Greene, Hickory, Jasper, Lawrence, Laclede, McDonald, Newton, Polk, Stone, Taney, Webster
NINTH	David O. Barbe, M.D., Mountain Grove	Mid-Missouri (135), South Central (206)	Crawford, Dent, Douglas, Howell, Maries, Oregon, Ozark, Phelps, Pulaski, Shannon(*), Texas, Wright
TENTH	William C. Shell, M.D., Sikeston	Butler-Wayne-Ripley-Carter (034), Cape Girardeau (042), Dunklin (070), Jefferson (106), Mineral Area (138), Pemiscot (170), Perry-Ste. Genevieve (174), SEMO (202)	Bollinger, Butler, Cape Girardeau, Carter, Dunklin, Iron, Jefferson, Madison, Mississippi, New Madrid, Pemiscot, Perry, Reynolds, Ripley, St. Francois, Ste. Genevieve, Scott, Stoddard, Washington, Wayne
Resident Physician Secton	Maria Evans, M.D., Columbia	Resident Physican Section (215)	Statewide
Hospital Medical Staff Section	Charles Barbee, M.D. Columbia		Statewide
Medical Students	Chris Hinrichs, St. Louis	Medical Students - St Louis University (216), University of Missouri - Columbia (218), University of Missouri - Kansas City (220), Washington University (222)	Statewide

(*) indiciates counties with no medical organizations

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MSMA 1993-94 Directory

Listings in this directory include:

- A photo listing of MSMA Officers, MSMA Councilors, Vice Councilors and AMA Delegates & Alternate Delegates. *see pages 371-375*
- Code of Medical Ethics. *see pages 377-78*
- A list of Association Policies. *see pages 379-384*
- MSMA Constitution & Bylaws. *see pages 385-392*
- Listing of Political Action Committee Contributors. *see pages 393-4*
- Listing of Members of MSMA Committees & Commissions. *see pages 395-6*
- Directory of State and Metropolitan Medical Specialty Organizations. *see pages 397-400*
- List of Insurance Options for members. *see page 402*
- Listing of MSMA Component Society Executives or Secretaries. *see page 404*
- Listing of abbreviations for medical specialties. *see page 548*
- State Map locating Districts & Component Societies with a Guide Table listing Councilors, Societies and Counties by District. Society Code numbers are listed at the bottom of this page. *see page 406*

Members are listed in three ways:

Alphabetical Roster of Members

Members are listed in alphabetical order. The listing includes the physician's city and the code number of the component society to which the member belongs. *see pages 411-446*

Membership Roster by Primary Specialties

Specialties are listed alphabetically. Members are listed under their specialty. This roster also includes members' towns and society code numbers. *see pages 447-475*

Roster of Membership by Component Society

Societies are in alphabetical order which is also the sequential order of the code numbers. The listing includes members' office address, phone number and the abbreviation of specialty. At the end of this roster is a listing of student members by school. *see pages 476-545*

Component Medical Society Codes

002	MSMA Only
010	Andrew
014	Audrain
018	Barton
026	Boone
030	Buchanan
034	Butler-Wayne-Ripley-Carter
038	Callaway
042	Cape Girardeau
046	Chariton-Macon-Monroe-Randolph
050	Clay-Platte
054	Clinton
058	Cole
066	Dallas-Hickory-Polk-Dade
070	Dunklin
074	Franklin-Gasconade-Warren
078	Grand River
082	Greene
086	Henry
102	Jasper
106	Jefferson
110	Johnson
115	Laclede
118	Lafayette-Ray
120	Lake of the Ozarks
125	Metro Med - Greater Kansas City
135	Mid-Missouri
138	Mineral Area
146	Montgomery
148	North Central
150	Northeast
158	Northwest
166	Ozarks
170	Pemiscot
174	Perry-Ste. Genevieve
178	Pettis
186	Pike
189	St. Charles-Lincoln
190	St. Louis Metropolitan
198	Saline
202	SEMO
206	South Central
208	Tri-Lakes
210	Webster
214	West Central
215	Resident Physician Section
216	St. Louis University
218	University of Missouri-Columbia
220	University of Missouri-Kansas City
222	Washington University

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Alphabetical Roster of Members

Including name of city and code number of each member's component medical society.

A

aron, Geo	Shawnee Mission	125
bada, Roland	St. Louis	190
badir, Rushdy	Columbia	026
bbadessa, Steven M	St. Louis	190
bbott, David A	St. Louis	190
bdou, Nancy L	Kansas City	125
bel, Charles C	St. Louis	190
bele, Wm A	Boonville	026
bella, Ben Zulueta	Belton	125
bend, Melvin N	Kansas City	125
bercrombie, Keith J	Kansas City	125
bernathie, Dennis L	Columbia	026
binoja, Conrado B	St. Louis	190
bodeely, Daniel A	St. Louis	190
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dams, W. Stuart	Florissant	002
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Albritton, Michael A	Springfield	082
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Alcancia, Elpidio Y	Springfield	082
Alderman, Lillian C	Liberty	050
Aldridge, George A	Poplar Bluff	034
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Alex, Morris	St. Louis	190
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Ali, Mohammed E	Independence	125
Ali, Syed S	Granite City	190
Allain, James J	Shawnee Mission	050
Allan, James E	Jefferson City	058
Allan, James R	Four Seasons	120
Allcorn, Donald K	Lincoln	178
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Allen, Arthur A, II	Shawnee Mission	125
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Allen, James H	St. Louis	190
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Allen, Jerry H	Washington	074
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Allen, Robert W	Columbia	026
Allen, Robt E	Kansas City	125
Allen, Thomas P	Kansas City	125
Allen, Willard M	Glenwood	190
Allen, William Corwin	Columbia	026
Allen, Wm C	Columbia	026
Allison, James B	Springfield	082
Allphin, Allan L	Springfield	082
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Almuttar, Wasif F	Maryville	158
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Alsop, Webb S, Jr.	Shawnee Mission	125
Altemeier, William A, III	Columbia	026
Altepeter, H. Martin	St. Louis	190
Altomare, Edward P	Kansas City	125
Alul, Mohammad Ali H	St. Charles	189
Alvarez, Ulises C	Florissant	190
Alyea, James O	Columbia	026
Ames, Mary B	St. Joseph	125
Amin, Navin J	St Louis	190
Amini, Jafar	Shawnee Mission	125
Amjad, Mohammad T	St. Louis	190
Ammatelli, Francis J	Kansas City	125
Amoury, Raymond A	Kansas City	125
Anbari, Martin M	Brentwood	215
Ancheta, Apolinario A	Springfield	082
Andersen, David A	St. Louis	190
Anderson, Charles B	St. Louis	190
Anderson, Daphne W	Springfield	082
Anderson, David J	St. Louis	190
Anderson, Dixie J	St. Louis	190
Anderson, Douglas A	Springfield	082
Anderson, Frank K	St. Charles	189
Anderson, Lynn A	Springfield	082
Anderson, Paul B	Neosho	166
Anderson, Philip C	Columbia	026
Anderson, Raymond B	Shawnee Mission	125
Anderson, Sue K	Prairie Village	125
Anderson, Thos R	Columbia	026
Andres, Edward H	St. Joseph	030
Andrew, Christopher R	Joplin	102
Andrews, Elizabeth J	Springfield	082
*Andrews, Lynthia B	Kansas City	030
Andrews, Paul E	Springfield	082
Andrus, Bailey C	Leawood	125
Andrus, Charles H	St. Louis	190
Anglen, Jeffrey O	Columbia	026
Anglo, Luis J	Columbia	215
Anglo, Luis B	St Louis	190
Anslinger, David L	Chesterfield	190

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Anstey, Geo C	St. Ann	190
Anstey, John T	St. Ann	190
Anthony, Dallas D	Springfield	082
Anthony, James P	Kansas City	125
Apostol, Andres G	Monett	166
Appelbaum, James S	Kansas City	125
Appelbaum, John K	St. Louis	002
Applewhite, Thomas A	St. Louis	190
Apprill, Phillip G	St. Louis	190
Apte, Sunil M	Washington	074
Arbab, Ali A	Kansas City	125
Arbaugh, Scott J	Florissant	190
Archer, Carol R	St. Louis	002
Arends, Todd W	Chesterfield	190
Arenos, Proceso T	St. Louis	190
Arias, Fernando	St Louis	190
Armstrong, Jay H	Hesperia	050
Armstrong, Stephen D	Springfield	082
Arneson, Axel N	St Louis	190
Arney, Wm G	St. Louis	190
Arnold, John D	Shawnee Mission	125
Arnold, Kenneth J	Chesterfield	190
Arnold, Paul N	Springfield	082
Arnot, John P	St Louis	190
Aronberg, Jerome M	St Louis	190
Arribas, Aurora I	Kansas City	125
Arribas, Neva P	St Louis	190
Arribas, Romeo F	Blue Springs	125
Arst, Herbert E	Kansas City	050
Arthaud, J B	Columbia	026
Asaro, Phillip V	St. Louis	190
Asel, Norman D	Columbia	026
Ash, Charles J	Springfield	082
Ashby, Jennifer D	N. Kansas City	125
Ashcraft, Keith W	Overland Park	125
Ashcraft, Walter C	Crystal City	106
Asher, Irving M	Columbia	026
*Asher, Kennett D	Jackson	042
Ashley, Lillard G, Jr.	Kansas City	125
Ashley, Michael E	Springfield	082
Ashley, Thos E	Springfield	082
Askew, John H	Sikeston	202
Assi, Nizar A	St. Louis	190
Assil, Kerry K	St. Louis	190
Atchison, Amy L	Kansas City	215
Atkinson, Lance D	Springfield	082
Atwell, Floyd C	Shawnee Mission	125
Aubuchon, Craig E	St. Louis	190
Auclair, Ronald J	St. Louis	190
Auer, Arthur I	St Louis	190
Aufderheide, G. Russell	St Louis	190
Augustin, Cesar	St. Louis	190
Aulenbacher, Carl E	Ft. Lauderdale	074
Auner, Cecil R	Springfield	082
Auner, J. David	Ironton	138
Austin, Craig T	Roeland Park	215
Austin, George M	Blue Springs	125
Avallone, Anthony N	Springfield	082
Averill, Keith H	Mission Hills	125
Avery, David M	Springfield	082
Avins, Laurence R	St. Louis	190
Avioli, Louis V	St. Louis	190
Awadalla, Sylvia	St. Louis	190
Axness, Mark E	Springfield	082
Ayata, Sedat M	St Louis	190
Aydt, Sarah A	Cape Girardeau	042
Aykent, Yavuz	St. Louis	190
Aylward, Howard J, Sr.	Santa Barbara	190
Aylward, Howard J, Jr.	St. Louis	190
Ayres, Willa J	Kansas City	125
Ayvazian, Vatche H	St. Louis	190
Azan, Abraham N	Sedalia	178
Azan, Kenneth N	Sedalia	178
Azzam, Farid J	St. Louis	190

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*Baade, Norman F	St. Joseph	030
Babka, Joseph J	St. Louis	190
Bach, Lysle M	Hannibal	150
Back, Donald K	Springfield	082
Backer, Matt H, Jr.	St. Louis	190
Backer, Robert J	St. Louis	190
Backstrom, Jay T	Kansas City	125
Bade, Bruce	Moberly	046
*Bader, Larry W	Columbia	026
Bagby, Jack M, Jr	Springfield	082
Baglan, Robert J	St. Louis	190
Bagwe, Lata R	St. Louis	190
Bagwe, Ranjit M	St. Charles	189
Bahn, Charles F	Prescott	042
Bai, Samuel S	Festus	106
Baik, Kenneth Y	Marshall	198
Bailey, Alan H	Springfield	082
Bailey, Gregory J	St. Louis	190
Bailey, Hugh R	Kansas City	002
Bailey, Marsha L	Arnold	190
Bailey, Sean B	St. Louis	215
Bailiff, Robert	Springfield	082
Baird, Keim L	St. Charles	189
Baker, Carl N	St. Louis	190
Baker, Donald L	Union	074
Baker, Eric K	Independence	215
Baker, Josephine D	Moberly	046
Baker, Marion H	Liberty	215
Baker, Philip J	Independence	125
Baker, Sherwood	Columbia	026
Bal, Deepinder S	Overland Park	215
Balcer, Charlotte M	Jefferson City	058
*Balcer, Conrad S	Jefferson City	058
Baldassare, Andrew R	St. Louis	002
Baldwin, Richard M	Springfield	082
Baldwin, Richard , Jr.	St. Louis	190
Baldwin, Theodore R	Excelsior Spgs.	118
Bale, Robert D	St. Louis	190
Balfe, Dennis M	St. Louis	190
Ball, David A	Joplin	102
Ballard, V. Bryce	Shawnee Mission	125
Ballinger, Walter F	St. Louis	190
Balster, Vernon H	St. Louis	190
Bandle, Donald F	St. Louis	190
Banerjee, Dilip	Washington	074
Banez, Colita R	St. Louis	190
Banton, M. Roman	St. Louis	190
Banton, Thomas J, Jr.	Florissant	190
Banton, William C, II	St Louis	190
Barbe, David O	Mountain Grove	206
Barbee, Chas W	Columbia	026
Barber, Gregory B	Kansas City	125
Barbour, Marvin R	Poplar Bluff	034
Bardsley, John L	St Louis	190
Bare, Chester I, Jr.	Kansas City	125
Bare, Edward F	Tarkio	158
Bareis, Robt J	Marshfield	210
Barelli, Pat A	Shawnee Mission	125
Bari, Wagih A	St. Louis	190
Barker, Edward T	St Louis	190
Barloon, James H	Kansas City	125
Barlow, Val John	Chesterfield	190
Barnard, John L, Jr.	Kansas City	125
Barnes, Larry G	Neosho	166
Barnett, Floyd A	Paris	046
Barnhill, Floyd R	Springfield	082
Barnthouse, Cris D	Kansas City	125
Barnthouse, Joseph R	Kansas City	125
Barr, Glenn A	Kansas City	125
Barr, W. Kent	Kansas City	125
Barragan, Hector D	St. Louis	190
Barrett, Scott R, Sr.	Columbia	190
Barrow, Jack	St. Louis	190
Barry, Stephanie L	Mission	215
Barry, Wm B	Kansas City	125
Bart, Gerald N	St. Louis	190
Bartell, Michael F	St. Louis	190
Barter, Bruce	Kansas City	125
Bartholomew, Kenneth K	Quincy	002
Bartlett, Hugh C	Rolla	135
Bartlett, John E	Springfield	082
Bartley, Richard L	Springfield	082
Barton, Jean C	Excelsior	125
Barton, Premsri T	St. Louis	190

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Bartulica, Nicholas	St. Joseph	030
Bashford, Eileen A	N. Kansas City	050
Baska, Richard E	Kansas City	125
Baskurt, Mehmet V	Poplar Bluff	034
Basler, Joseph W	Crestwood	190
Bass, Barry J	Rolla	135
Bass, Elliott L	Kansas City	125
Bass, Walter R	Raytown	125
Bassman, Donald R	St. Louis	190
Batan-Co, Ruby L	Chesterfield	190
Bateman, Timothy M	Kansas City	125
Bates, G. Comer	Kansas City	050
Batts, Barbara A	Kansas City	125
Baue, Arthur E	St. Louis	190
Bauer, Daniel J	St. Louis	190
Bauer, John D	St. Louis	190
Bauer, Lafe W	Prairie Village	125
Bauer, Martin L	Prairie Village	125
Baula, Armindo G	St. Louis	190
Bauman, Alan E	Kansas City	125
Bauman, Henry C	St. Joseph	158
Baumann, Albert R	Steelville	135
Baumann, Daniel J	St. Louis	190
Baumer, Kevin A	St. Louis	215
Bauschard, Frederick D	St. Louis	190
Bautista, Rogelio L	Moberly	046
Bautz, James B	Kansas City	125
Bauwens, Daniel B	Chesterfield	190
Bay, Merrill R	Blue Springs	125
Bayer, William L	Kansas City	125
Beal, Catherine E	St. Louis	190
Beal, Douglas W	Columbia	026
Bealer, Laura A	Kansas City	215
Beall, McPherson S, Jr.	Kansas City	125
Beare, Lucia V	St. Louis	190
Beato, David L	St. Louis	190
Beatty, Eugene C	Shawnee Mission	125
Beatty, Robert M	Kansas City	125
Beaty, Wm R	St. Ann	190
Beauchamp, Gary D	Shawnee Mission	125
Beck, Marcus R	Columbia	026
Beck, Paul M	St. Joseph	030
Becker, Bernard	St. Louis	190
Becker, Robt L	St. Louis	190
Becker, Rolfe A	Kansas City	125
Becker, Stanley C	St Louis	190
Becker, William L	St. Louis	190
Beckett, Wm. Wilson	Columbia	026
Beckette, Edmund	St. Louis	190
Beckman, Robert F	St. Louis	002
Bedwinek, John M	St. Louis	190
Beechwood, Emory C	St. Louis	190
Beeks, John W	Kansas City	125
Beesley, Kari	Kansas City	002
Behbahani, Parviz M	Bridgeton	190
Beheler, Edward M	St. Joseph	030
Behrend, Ann E	Kansas City	125
Behrends, Steven H	Kansas City	125
Behrens, Donald T	St Louis	190
Behrens, Gerald L	St. Louis	190
Beidle, Raymond J	Bridgeton	190
Beitman, Bernard D	Columbia	026
Belden, Edgar A	Jefferson City	058
Belden, Jeffery L	Columbia	026
Belen, Marietta	Festus	106
Belew, Joe E	Chesterfield	190
Belew, Mark	Florissant	190
Bell, Hubert H	Kansas City	125
Bell, Laird A	Springfield	082
Bell, Malinda H	Shawnee Mission	125
Bell, Martin J	St Louis	190
Bell, Stephen	St. Louis	190
Bell, Wm F	Lee's Summit	125
Beller, Thomas A	Kansas City	125
Belshe, Robert B	St. Louis	190
Belshe, Sidney B	Jefferson City	058
Benage, Clarence M	St. Louis	190
Benecke, James E, Jr.	St. Louis	190
Benedett, Robert E	Springfield	082
Benedict, William W	Chesterfield	190
Benitez, Jose A	St. Louis	190
Bennett, Danny L	Kansas City	125
Bennett, James D	Leawood	125
Bennett, John E	Jefferson City	058
Bennett, Kenneth J	St. Louis	190
Bennett, Robert U	Springfield	082
Benoist, Walter F	Chesterfield	190
Benson, Larry E	N. Kansas City	050
Benson, Ronald G	Springfield	082
Benson, Russell L	Lee's Summit	125
Benson, Scott C	Mesa	030
Benson, William F	Kansas City	125
Bentlage, Charles H	Joplin	102
Bentley, John D	Springfield	082
Benton, Mary Beth	Columbia	026
Berdy, Gregg J	St. Louis	190
Berdy, Susan S	St. Louis	190
Berenson, Cathy E	Mission Hills	215
Berg, Edward F	Chesterfield	190
Berg, Leonard	St. Louis	190
Berg, Ralph	St Louis	190
Berger, Adam S	St. Louis	215
Bergmann, Daniel J	St. Peters	189
Bergmann, Martin	St. Louis	190
Bergner, Grace E	St. Louis	190
Berkowitz, Ellis R	St. Joseph	030
Berkowitz, Wallace P	St. Louis	190
Berland, David I	St. Louis	190
Berland, Harry I	St. Louis	190
Berman, Wm	St. Louis	190
Bernabe, Florinio H	St. Louis	190
Bernabe, Ofelia M	St. Louis	190
Bernard, Jennifer P	Kansas City	215
Bernard, Lisa	Kansas City	125
Bernardi, Robert J	Wauwatosa	215
Berndsen, Gerard H	St. Louis	190
Berner, Carol T	Springfield	082
Bernhardt, Gary D	Overland Park	125
Bernhardt, Mark	Kansas City	125
Berni, Anthony A	St Louis	190
Bernstein, Aaron M	St Louis	190
Bernstein, Brad	St. Louis	190
Berry, Danny T	Cape Girardeau	042
Berry, Maxwell G	Shawnee Mission	125
Berry, Paul T	Springfield	082
Berwald, David M	Bridgeton	190
Berwald, Irvin I	Bridgeton	190
Bessey, Palmer Q	St. Louis	190
Best, John F	Springfield	082
Best, John A	Chesterfield	190
Bettinger, Irene E	Kansas City	125
Bettonville, Paul J	St. Louis	190
Bettonville, Peter V	St. Louis	190
Betz, Richard J	Neosho	166
Betz, Robert F	Neosho	166
Bever, Grant A	Harrisonville	214
Bhat, Sanjay T	Manchester	002
Bhattacharjee, Lakshmisri	Kansas City	215
Bhattacharya, Arjun	St Louis	190
Bhothinard, Bhisit	Poplar Bluff	034
Biber, Robert J	Independence	125
Bick, Linda G	St. Louis	190
Bickel, Vern T	Lamar	018
Bickley, James E	Kansas City	125
Biel, Stanley I	Bridgeton	190
Bieniek, Christopher M	Hannibal	150
Biermann, Robin S	Jefferson City	058
Biery, Richard M	Kansas City	125
Biest, Ann Agnew	Brentwood	002
Bigg, Steven W	St. Louis	190
Biggs, Alfred D, Jr.	Kansas City	125
Biggs, Fred J	Poplar Bluff	034
Biggs, Harry L	Galena	125
Biggs, John	St Louis	190
Bilchik, Ronald C	Chesterfield	190
Billy, Lawrence J	Florissant	190
Binda, Robert E	Kansas City	125
Bindbeutel, Donald A	Chesterfield	190
Binnington, H B	St Louis	190
Binz, Donald E	St. Peters	189

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Birchansky, Bonnie-Lee	030	St Joseph
Bircher, John L	190	St. Louis
Bird, H. Waldo , Jr.	190	St Louis
Bird, Jonathon M	138	Farmington
Birenboim, Nancy	125	Kansas City
Birge, Clifford A	190	Richmond Hghts
Birkby, Wm F	215	Columbia
Birmingham, Jean E	190	St. Louis
Birnbaum, Elisa H	190	St. Louis
Bishop, Marion D	190	St. Louis
Bitar, Saad R	215	Manchester
Bizek, J L	166	Aurora
Black, David L	102	Joplin
Black, Don A	125	Prairie Village
Black, Joseph T	190	St Louis
Black, Kevin J	215	St. Louis
Black, Thomas C, Jr.	125	Kansas City
Blackburn, Michael D	026	Columbia
Blackman, Cameron T	215	St. Louis
Blackwell, Charles R	190	St. Louis
Blackwell, Chas W	026	Columbia
Blades, Ross D	082	Springfield
Blaine, James R	082	Springfield
Blair, Olga M	190	St. Louis
Blair, Vilray P, III	190	St. Louis
Blalock, Robt W	198	Marshall
Blanchard, Gary W	190	Gonzales
Blank, Michael K	106	De Soto
Blanke, Thomas J	190	St. Louis
Blankenship, Dale M	042	Savannah
Blankenship, Geo W	166	Neosho
Blanton, Jos C	202	Sikeston
Blaskiewicz, Robert J	190	St. Louis
Blath, Richard A	190	St. Louis
Blatt, Geoffrey L	125	Kansas City
Blim, R. Don	125	Kansas City
Blinder, Kevin J	026	Columbia
Block, Arnold S	190	St. Louis
Bloom, Jeffrey N	190	St. Louis
Bloom, Stephen A	125	Kansas City
Bloomberg, Gordon R	190	Chesterfield
Bluestone, Kenneth I	125	Kansas City
Blum, Carol A	002	Excelsior Spgs.
Blum, Donald A	190	St. Louis
Blum, Philip C	125	Kansas City
Blumenthal, Mark F	190	Bridgeton
Blythe, James G	190	St Louis
Boatright, Kevin	138	Farmington
Bocchini, Thomas P	002	St. Louis
Bock, David B	125	Kansas City
Bock, Linda P	190	St. Louis
Bode, Eugene T	125	Kansas City
Bodenhausen, Gary E	125	Blue Springs
Boedeker, James P	190	St. Louis
Bogart, Douglas B	125	Kansas City
Bohigian, George M	190	St. Louis
*Bohn, Sara A	002	California
Bohn, William W	125	Kansas City
Bohon, Barbara D	125	Kansas City
Boldizar, Albert G	190	St Louis
Boldt, Thomas H	190	Bridgeton
Boles, C R	190	St. Louis
Boles, Murray	026	Columbia
Bolinske, Robt E	190	St. Louis
Bollier, Rene P	125	Overland Park
Bollozos, George D	190	Chesterfield
Bonacorsi, John	190	Bridgeton
Bondurant, Charles P	215	Columbia
Bonebrake, Albert J	082	Springfield
Bonebrake, Mac D	082	Springfield
Bonfanti, Albert L	190	Bridgeton
Bonham, Roger D	026	Columbia
Boniuk, Isaac	190	St. Louis
Bonner, James S	190	St. Louis
Bonney, Saml C	074	Washington
Bonsanti, Robt L	190	Bridgeton
Boone, Daniel C	050	Kansas City
*Boone, Gina E	002	Smithville
Boone, Martin H, Jr	082	Springfield
Boone, Vicky L	082	Springfield
Boonshaft, Benje	190	St Louis
Bopp, J. Ronald	102	Joplin
Bopp, Sandra L	002	Brentwood
Borders, Jeffrey L	002	Kansas City
Bordy, Marvin D	125	Kansas City
Borello, Dan J	102	Joplin
Borja, Egbert R	082	Springfield
Borkon, A. Michael	125	Kansas City
Borowsky, Benj A	190	St. Louis
Borrego, Raul A	138	Farmington
Borup, Jerrell L	082	Springfield
Botney, Kathryn	190	Chesterfield
Botwin, Arnold E	125	Leawood
Bouhasin, John D	190	St Louis
Boullier, John A	190	St. Louis
Boulware, William T	078	Chillicothe
Bourgeois, Curtis H	026	Columbia
Bourjolly, Wilson P	190	Florissant
Boveri, Jos C	190	St Louis
Bowdern, Edward H	190	St Louis
Bowe, Christopher C	190	St. Louis
Bowen, Stephen F, Jr.	190	St Louis
Bowen, William G	190	St. Louis
Bowenschulte, Bradley A	082	Springfield
Bower, James S	125	Kansas City
Bowers, Gregory R	202	Matthews
Bowers, James E	190	St. Louis
*Bowers, James L	215	St. Joseph
Bowersox, Warren A	190	Pacific
Bowles, G R	190	St Louis
Bowles, Richard P	050	Liberty
Bowles, Wm T	190	St Louis
Bowlin, Steven K	125	Kansas City
Bowman, Melvin C	166	Neosho
Bowman, W. Kirk	042	Cape Girardeau
Bowser, John F	125	Hot Springs
Bowser, Robert L	050	Independence
Boyarsky, Saul	190	St. Louis
Boyce, John M	178	Sedalia
Boyd, Craig W	190	St. Louis
Boyd, George K	125	Shawnee Mission
Boyd, James H	190	St. Louis
Boydston, Catherine O	118	Odessa
Boydston, Wyatt W	118	Odessa
Boyer, Peter A	058	Jefferson City
Boylan, Peter C	125	Kansas City
Brabbee, Gregory W	190	St. Louis
Brabson, John H	082	Springfield
Bradford, John F	125	Kansas City
Bradley, J. Douglas	030	St. Joseph
Bradley, James K	002	Kansas City
Bradley, Richard V	190	St. Louis
Bradley, Wm W	026	Centralia
Bradshaw, Wm D	125	Kansas City
Brady, Harry R	190	St Louis
Brady, Hugh S	118	Concordia
Brady, Jane R	215	St. Louis
Brancato, Donald H	190	St Louis
Branch, Walter D, JR	125	Kansas City
Brand, Stanley N	125	Kansas City
Brandon, Frederick M	215	Oklahoma City
Brandwin, Leslie M	190	St. Louis
Brangle, Robt W	190	St Louis
Branham, Gregory H	190	St. Louis
Braun, Alan L	058	Jefferson City
Braun, William J	125	Kansas City
Braunschweig, Ralph	026	Columbia
Braverman, Abe E	125	Kansas City
Braverman, Stuart J	178	Sedalia
Braxton, Frank W	042	Cape Girardeau
Brazos, John C	178	Sedalia
Breckenridge, Robert L	050	Kansas City
Bredemann, Jeffrey A	125	Parkville
Breeden, Richard L	135	Rolla
Breeding, Lyle G	026	Columbia
Bregant, Robt E	058	Jefferson City
Brehm, G. Scott	102	Joplin
Brehm, Martha A	102	Joplin
Brennan, Danl J	190	St Louis
Brennan, Geo A	190	St. Louis

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Brennan, James M	190	St. Louis
Brennan, Richard J	030	St. Joseph
Brennan, Robert A, Jr.	190	St. Louis
Brennan, Robt A, Sr.	190	St. Louis
Brennan, Robt V	190	St. Louis
Brent, Lanny R, Jr	082	Springfield
Bresnahan, Dennis R	125	Kansas City
Brewer, Joseph H	125	Kansas City
Brian, Wm J	082	Springfield
Bricker, Eugene M	190	St. Louis
Brigden, Robert B	102	Neosho
Briggs, Thomas B	082	Springfield
Brigham, David W	190	Ballwin
Bright, James E	082	Springfield
Brinkman, Mark F	215	Prairie Village
Brinkman, Robert A	190	Chesterfield
Bristow, Robert B	030	St. Joseph
Britt, Cornelius L	106	Crystal City
Britton, Loretta M	125	Kansas City
Broaddus, Loren E	082	Springfield
Brock, Arthur L	125	Independence
Brockhaus, Jayne R	002	Kansas City
Brockman, M. Douglas	082	Springfield
Brocksmith, James T	026	Columbia
Brodeur, Armand E	190	St. Louis
Brodkey, Mark J	125	Kansas City
Brody, Arnold G	190	St. Louis
Bronson, Shael S	190	St Louis
Brook, Charles J	125	Kansas City
Brookes, Robt D	190	Chesterfield
Brookreson, Alton D	034	Poplar Bluff
Brooks, John E	082	Rogersville
Brooks, Richard J	125	Kansas City
Broun, Goronwy O, Jr.	190	St. Louis
Brower, Clyde L	125	Independence
Brown, Adrian J	125	Kansas City
Brown, Barry D	190	St. Louis
Brown, Cynthia L	034	Poplar Bluff
Brown, David W	082	Springfield
Brown, Elwyn S	125	Kansas City
Brown, Frances S	125	Kansas City
Brown, Frederick B	166	Aurora
Brown, Freeman F, III	190	Ballwin
Brown, James T	082	Springfield
Brown, Katherine S	038	Overland Park
Brown, Merlin D	030	St. Joseph
Brown, Michael S	026	Columbia
Brown, Mike J	042	Cape Girardeau
Brown, Norbert W	125	Kansas City
Brown, Randy A	002	St. Louis
Brown, Robert J	189	St. Charles
Brown, Robt S	125	Shawnee Mission
Brown, Seymour	190	Chesterfield
Browne, Jon E	125	Kansas City
Brownsworth, Ronnie D	082	Springfield
Bruce, Helen L	190	St Louis
Bruce, Leo A	202	Sikeston
Bruce, Robert P	125	Kansas City
Brukardt, Diane T	026	Columbia
Brummett, Richard R, Jr.	030	St. Joseph
Brundidge, Phyllis K	002	St. Louis
Bruno, Ellen L	026	Columbia
Bruns, Kenneth	190	St. Louis
Brunt, Elizabeth M	215	St. Louis
Brunt, L. Michael	190	St. Louis
Brunts, John T	215	Kansas City
Brunworth, David	074	Washington
Bruso, Charles E	030	St. Joseph
Bryant, Lester R	026	Columbia
Bryant, T J	125	Kansas City
Buben, Robt W	150	Hannibal
Buchanan, Barbara N	125	Kansas City
Bucher, William C	026	Columbia
Buchert, Peter K	026	Columbia
Bucholz, Richard D	190	St. Louis
Buchwach, Kenneth A	125	Independence
*Buckler, Debra A	058	Jefferson City
Buckner, Robert C	125	Shawnee Mission
Budd, John J, Jr.	190	St. Louis
Budke, Harold A	125	Kansas City
Buehler, Carl T, Jr	120	Eldon
Buergler, John M	215	St. Louis
Buettner, John Brigham	190	Chesterfield
Buffaloe, Robert N	058	Jefferson City
Buie, Bruce R	125	Kansas City
Buie, Steven E	125	Kansas City
Bukstein, Michael J	150	Hannibal
Bult, Mark J	082	Springfield
Bumgarner, James E	026	Columbia
Bumgarner, Roger W	026	Columbia
Bunge, Nancy J	014	Mexico
Bunting, Williston P	125	Kansas City
Burch, John E	102	Naples
Burch, Timothy K	125	Overland Park
Burcham, Tom R	042	Farmington
Burdge, Robert E	190	St. Louis
Burford, Edwin K	042	Cape Girardeau
Burgdorf, Max H	190	Bridgeton
Burgess, Dean	190	St Louis
Burk, Emmett K	050	Irving
Burkey, Jordan W	082	Springfield
Burkhart, Edward F	190	St. Louis
Burks, Michael L	026	Columbia
Burleigh, Bruce W	102	Joplin
Burmeister, R. William	190	St. Louis
Burns, Edward L	190	St. Louis
Burns, Francis J	190	St. Louis
Burns, Michael F	190	St. Louis
Burns, Richard W	215	Jefferson City
Burns, Robert P	026	Sonoma
Burns, Thos W	026	Columbia
*Burris, Charles W	190	St. Louis
Burris, Garrett C	190	Chesterfield
Burroughs, Nathan D	050	N. Kansas City
Burry, Virgil F	125	Blue Springs
Burst, Donald O	190	St. Louis
Burstein, Robert	190	Richmond Hghts
Burton, Curtis D	150	Hannibal
Bury, Jan	215	Overland Park
Bury, Robert J	002	Overland Park
Busch, Anthony K	190	Belleville
Busiek, Paul J	082	Springfield
Busse, Paul P	190	St. Louis
Bussmann, Carl E	190	Bridgeton
Bussmann, Donald W	190	Chesterfield
Bussmann, Donald W, Jr	082	Springfield
Bussmann, Yvonne L	082	Springfield
Butin, Richard E	125	Kansas City
Butler, Elza F	030	St. Joseph
Butler, Richard L	215	Godfrey
Butler, Stephen M	150	Hannibal
Butsch, Richard H	190	St. Peters
Butterfield, Mari Anne	125	Lee's Summit
Butterworth, Nelson S	125	Kansas City
Butts, James D	135	Rolla
Byars, Steven R	125	Kansas City
Byland, Saml J	146	Wellsville
*Bynum, Robert L	026	Ashland
Byrum, Fritz A	190	Ballwin

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Cabal, Edito	190	St. Louis
Cabal, Maria	190	E. St. Louis
Cabanas, Justo J	125	Shawnee Mission
Cabbabe, Edmond B	190	St. Louis
Cabral, Galileu	190	St. Louis
Cabrera, Tomas V	189	St. Peters
Caciolo, Barbara A	190	St. Louis
Cacioppo, Jos E	190	St. Louis
Cady, Roger K	082	Springfield
Caffrey, Raymond J	125	Independence
Cain, Alvin R	018	Lamar
Cajili, Antonio T	190	Ballwin
Calabria, Rafael	214	Nevada
Calbert, Cythia C	125	Kansas City
Caldwell, Fred	034	Poplar Bluff
Caldwell, Fred M	034	Poplar Bluff
Caldwell, John K	125	Kansas City
Caldwell, Joseph L	082	Springfield
Calhoun, Joshua W	190	St. Louis

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Calhoun, Kirk A	Kansas City	125
Callahan, Donald E	St Louis	190
Callahan, Jos D	St Louis	190
Callaway, Guy D, Jr	Springfield	082
Callaway, Jo J	Kansas City	125
Callaway, Lawrence A	Kansas City	125
Callegari, Paul R	St. Louis	190
Callicoat, Paul E, Jr.	Joplin	102
Calman, Carl H	St. Louis	190
Calodney, Martin M	St. Louis	190
Calovich, Emery R	Shawnee Mission	125
*Cameron, Roger W	Jefferson City	058
Camp, Alan D	Bridgeton	002
Campbell, Albert J	Sedalia	178
Campbell, Daniel C	Mount Vernon	166
Campbell, Edward D	Cape Girardeau	042
Campbell, Gregory S	Columbia	026
Campbell, J. William	St. Louis	190
Campbell, James E	Macon	046
Campbell, James W	Advance	202
Campbell, John G	Kansas City	125
Campbell, William S, Jr	Cape Girardeau	042
Campos, Francisco J	St. Louis	190
Canaan, Samuel A, Jr.	St Louis	190
Canale, John P	St. Charles	189
Cancelada, Juan	Farmington	138
Canent, Ramon V	Kansas City	125
Canlas, Mario P	Springfield	082
Cannon, Richard E	St. Charles	189
Cantor, Harvey E	St. Louis	190
Canty, Eugene J	St. Charles	189
Caplin, David A	St. Louis	190
Carden, Juan O	St. Louis	190
Carleton, Chas E	Farmington	138
Carlin, Albert L	Stanberry	158
Carlin, M. Richard	St. Louis	190
Carls, Garry L	Imperial	190
Carlson, Arne E	Creve Coeur	190
Carlson, Hjalmar E	Overland Park	125
Carlson, John V	Mexico	014
Carlton, Lynn N	Springfield	082
Carmody, John P	St. Louis	190
Carnahan, Chas E	Columbia	026
Carnell, Billy M	Buffalo	066
Carnes, Victor M	Joplin	102
Carolla, Robert L	Springfield	082
Carothers, Karmel L	Independence	125
Carpenter, Geo T	St. Joseph	030
Carpenter, James L	St. Charles	189
Carpenter, Wallace	Rock Port	158
Carr, Phillip W	Springfield	082
Carranza, Mauro J	St. Louis	190
Carrier, John A	Ballwin	190
Carrington, Howard W	Lebanon	115
Carroll, Danny K	Belton	214
Carroll, Thos W	Lamar	018
Carron, Oscar A	Perryville	174
Carter, Edwin E	St. Louis	190
Carter, Gary L	N. Kansas City	125
Carter, James R	Neosho	166
Carter, James E, Jr.	Kansas City	125
Carter, Jodianne T	Chapel Hill	215
Carter, Ronald D	Columbia	026
Caruso, Alfred C	Kansas City	125
Caruso, Alfred A	Kansas City	125
Caruso, Peter J	Leawood	125
Cary, John M	Chesterfield	190
Case, Mary E	St. Louis	190
Case, Wm F	Kansas City	125
Casement, Brian A	Kansas City	125
Casey, Arthur L	St. Louis	190
Casey, Edwin J	St Louis	190
Casey, Eliot C	St Louis	190
Cashman, John W	Shawnee Mission	125
Casidy, Shannon L	Overland Park	215
Cason, Elbert H	St. Louis	190
Cassat, James D	Washington	074
Cassels, John W, Jr.	Columbia	026
Castaneda, Marco A	Bridgeton	190
Caster, Philip W	Lebanon	115
Catanzaro, Anthony F	St Louis	190
Catanzaro, Frank J, Sr.	St Louis	190
Catanzaro, Frank J, Jr.	St. Louis	190
Catanzaro, Rudolph E	St Louis	190
Catron, David O	Cape Girardeau	042
Caughron, Michael R	Kansas City	125
Cayabyab-Loe, Lilibeth P	St. Louis	215
Ceaser, Nancy H	Springfield	082
Centner, Paul J	Prairie Village	125
Cento, Donald	Sikeston	202
Cernik, Christine M	St. Louis	190
Chadaratana, Phadung	St Louis	190
Chaffin, Jerald D	Branson	208
Chalk, David E	Washington	074
Chalkley, Judson I	Columbia	026
Chamness, James T	Vero Beach	190
Chan, Kwan-Ho "Casey"	Joplin	102
Chanasue, John A	Florissant	190
Chandler, Robt A	Kansas City	125
Chandra, Mahesh	Independence	125
Chandramohan, Nanjappa	Carthage	102
Chang, Chil K	Columbia	026
Chapman, James B	Cape Girardeau	042
Chapman, Jean A	Cape Girardeau	042
Chapman, Ramona Marie	Joplin	102
Charapata, Steven G	Kansas City	125
Charette, Richard P	Kansas City	125
Charles, Benj H	St. Louis	190
Charles, Elaine Z	St. Louis	190
Charles, Francois	St Louis	190
Charnas, Raymond M	St. Louis	190
Chase, Larry K	Springfield	082
Chase, Ned B	Joplin	102
Chastain, Chas W	Flat River	138
Chaudhari, A. Basit	Cape Girardeau	042
Chaudhuri, Tapan K	Raytown	125
Chaudhury, Triptesh K	Port Arthur	002
Chauhan, Nazar C	Poplar Bluff	034
Chavala, Sudarsan	Maryville	158
Chavez, Salvador	St. Louis	190
Chavez, Victor M	St. Louis	215
Cheek, Chas W	Columbia	026
Chehval, Micheal J	St Louis	190
Chellappa, Danu	Joplin	102
Chen, Alan J	Dexter	202
Chern, Mou S	Ava	206
Chernoff, Selbert G	Lee's Summit	125
Cherre, Charles J	Chesterfield	190
Chesney, George W	Joplin	102
Chesney, John W	Joplin	102
Cheuk, Shu-Sum	Chesterfield	190
Cheung, K. Charles	Cape Girardeau	042
Chilton, Jonathan D	Kansas City	125
Chin, Mark Maw-Chang	Chesterfield	190
Chinsky, Murray	St. Ann	190
Chipongian, Raul A	St. Louis	190
Chirino, Octavio R	St. Louis	190
Chishti, M. Ishaq	St. Louis	190
Cho, Kyu S	St Louis	190
Chod, Ronald J	Chesterfield	190
Choi, Dennis W	St. Louis	190
Choi, Sei Young	St. Charles	189
Chopra, Atul L	Columbia	215
Chou, Alice Hsing-Fen	Shawnee	215
Choudhury, M. Hasan	Houston	206
Chouinard, Michael P	Sikeston	202
Chow, Susanne M	Overland Park	125
Christ, Martin H	St. Joseph	030
Christiansen, Sidney G	St. Joseph	030
Christiansen, Stephen D	Springfield	082
Christianson, Chas S	Mount Vernon	166
Christy, John P	Poplar Bluff	034
Christy, Raymond A	Springfield	082
Christy, Richard R	Springfield	082
Chu, Fred C	Chesterfield	190
Chu, Peter Y	Kansas City	125
Chun, Chung S	Kansas City	125
Chun, Duck S	St. Louis	190
Chung, Kap Eun	Fredericktown	138
Chung, Sophia M	St. Louis	190

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Chung, T. David	Poplar Bluff	034
Churchill, Robert J	Columbia	026
Churchill, Stephen W	Kansas City	125
Ciapciak, Stanley J	St. Louis	190
Cibis, Gerhard W	Kansas City	125
Clark, David P	Columbia	026
Clark, Gail L	Chesterfield	002
Clark, Gayln V	APO	125
Clark, Granville E	Kansas City	125
Clark, Irving H	Overland Park	125
Clark, Larry K	Joplin	102
Clark, Lin W	Blue Springs	002
Clark, Mark S	Kansas City	215
Clark, Robert C	St. Joseph	030
Clarke, Michael S	Springfield	082
Clarke, Michael J	Springfield	082
Claseman, Wilma W	St. Louis	190
Clawson, James W	Springfield	082
Claycomb, Gerald K	Chesterfield	190
Clayton, Edgar L	Springfield	082
Clemens, Robert M	Sedalia	178
Clever, Henry W	St. Charles	189
Clever, Victor G	St. Charles	189
Cline, Daniel M	Kansas City	125
Cline, Merle A	Kansas City	125
Cline, Patricia W	Liberty	125
Clohisy, John C	St. Louis	215
Cloogman, Howard M	Overland Park	125
Clothier, Robt W	Independence	125
Clough, Chas A	Kansas City	125
Clouse, John W	Springfield	082
Clymer, David J	Kansas City	125
Coates, James G	St. Charles	190
Cobb, Milton L	St. Louis	190
Cochran, David S	Springfield	082
Cochran, Thos E	Springfield	082
Cockerell, Sanford F	Independence	125
Coffee, Amos L	Willow Springs	206
Coffin, Cheryl M	St. Louis	190
Coffin, Helen K	Shawnee Mission	125
Cohen, Bruce H	St. Louis	190
*Cohen, Donald L	Kansas City	125
Cohen, Edward	St. Louis	190
Cohen, Frank	Bridgeton	190
Cohen, Harry K	Overland Park	125
Cohen, Harry B	Mexico	014
Cohen, Hillard K	St. Ann	190
Cohen, Joel N	Springfield	082
Cohen, Marvin C	Kansas City	125
Cohen, Robert S	St. Louis	190
Cohrs, Clarence C	Moberly	046
Coin, Richard E	St. Louis	190
Cokingtin, Cliff	Leawood	125
Cokingtin, Diana L	Raytown	125
Cokingtin, Leovigildo C	Independence	125
Colbert, Robt S	Sikeston	202
Cole, Donald E	Kansas City	002
Cole, F. Sessions	St. Louis	190
Cole, Harry O	Chesterfield	190
Cole, Sherman W	Kansas City	125
Cole, Wm R	Sedalia	178
Coleman, Kevin A	Atlanta	215
Coleman, Matthew J	Cape Girardeau	042
Coleman, Terrence W	Independence	125
Colglazier, Mary C	Lee's Summit	125
Collins, Douglass D	Springfield	082
Collins, John W, Jr.	Independence	125
Collison, R Michael	Springfield	082
Colom, George A	Kansas City	125
Colter, Kim D	Washington	074
Colton, Eric S	St. Louis	215
Colton, Sharon M	Columbia	215
Colwill, Jack M	Columbia	026
Colyer, Jeffrey W	Shawnee Mission	215
Comas, Manuel R	St. Louis	190
Comens, Ruth C	St Louis	190
Comfort, Geo D	Mexico	014
Commerford, John F	St. Charles	189
Conant, James F	St. Joseph	030
Conde, Gary A	Joplin	102
Conlin, Chris	St. Louis	002
Conn, Robert D	Kansas City	125
Conner, Patrick T	Springfield	082
Conner, W. Edwin	Kansas City	125
Conoyer, J. Michael	St. Peters	189
*Conrace, Joseph E	Joplin	102
Conrad, Marshall B	St. Louis	190
Conrad, Raymond C	Springfield	082
Conway, Robert R	Columbia	026
Cook, James R	Springfield	082
Cook, Jerry W	Kansas City	002
Cook, Katherine S	Rolla	135
Cook, Marvin	St Louis	190
Cook, Paul R	Columbia	026
Cook, Thos B	Richmond	118
Cooksey, Jon D	St. Louis	190
*Cooley, Tonya T	Independence	215
Cooper, Barry R	N. Kansas City	050
Cooper, Barry J	St. Louis	190
Cooper, C. Wesley	Springfield	082
Cooper, Chas W, II	Jefferson City	058
Cooper, Gary D	Liberty	050
*Cooper, Glen E	Columbia	026
Cooper, James F	Bridgeton	190
Cooper, Robert W	Camdenton	120
Cooper, Robt L, II	Warrensburg	110
Cooper, Thomas J	Farmington	190
Cooper, Thomas J	Fulton	038
Coordes, Cordie C	Chesterfield	190
Cope, James C	Sanibel	026
Copeland, Jeffrey G	St. Charles	189
Copp, Ralph	St. Louis	190
Coppinger, Thos A	Kansas City	125
Corcoran, Francis H	Joplin	102
Corday, Robt J	St. Louis	190
Cordell, Larry D	Kansas City	125
Corder, James C	St. Louis	190
Corder, Robt L	St. Joseph	030
Cordonnier, James K	Springfield	082
Cordover, Mitchell B	St. Louis	002
*Cornelison, Diane L	Lee's Summit	215
Cornwell, Karen R	Kansas City	125
Coronado, Mario A	St Louis	190
Corrado, Joseph A	Mexico	014
Corry, Francis M	Springfield	082
Corry, James M	St. Louis	190
Cortez, Edwin A	Kansas City	125
Cortner, Mary C	Kansas City	125
Corvalan, Juan C	St. Louis	190
Corwin, Kenneth D	St. Louis	190
Coscia, Robert L	Springfield	082
Cosens, Exec. Dir., Ron	Kansas City	001
Costello, John B	St. Louis	002
Costello, Jos P, Jr.	Chesterfield	190
Costen, William S	Chesterfield	190
Costigan, David J	St. Louis	190
Costin, Jimmy L	Poplar Bluff	034
Cotton, Thos R	Kansas City	125
Couch, Jeffrey M	N. Kansas City	050
Couchman, Ryan W	Kirkwood	190
Coulson, Forest H	Whitewater	042
Coulter, James W	Springfield	082
Coulter, Steven L	Kansas City	125
Couper, Nicholas B	Columbia	026
Courter, Larry P	Osage Beach	058
Covarrubias, Jorge A	Collinsville	190
Covert, Richard A	St. Louis	190
Cowan, John H	Overland Park	125
Cox, Curtis S	Jefferson City	058
Cox, James L	St. Louis	190
Cox, John P	Amazonia	030
*Cox, John M	Joplin	102
Cox, Mark T	Columbia	215
Cox, Thomas E	Cape Girardeau	042
Cox, W. Welby	Springfield	082
Coxe, Wm S	St Louis	190
Coyne, Patrick M	Florissant	190
Cozad, Scott C	Kansas City	125
Cozean, Charles H	Cape Girardeau	042
Crabtree, H. Mark	Springfield	082

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Crabtree, Jay B	Bolivar	066
Cradock, Thomas V	St. Louis	190
Crafts, David	St. Louis	190
Craig, Alan G	St. Louis	190
Craig, Richard O	St. Joseph	030
Craig, Robert D	St. Louis	002
Craighead, Michael L	Jefferson City	058
Cramer, Quentin	Kansas City	125
Crandall, Richard E	Chesterfield	190
Crane, James P	St. Louis	190
Crane, John B	Washington	074
Crane, John L	Lee's Summit	125
*Crane, William G	Mission	215
Crapotta, Joseph A	St. Louis	002
Cravens, William P	Fulton	038
Craver, Jeffrey L	Bridgeton	190
Crawford, Katherine J	Carrollton	190
Crawford, Oral B	Springfield	082
Creech, Fred T	Columbia	026
Crepps, Louis F	St. Louis	190
Crespin, Stephen R	St Louis	190
Crespo, Horacio T	Warrenton	074
Crespo, Remedios R	Warrenton	074
Creswell, Lawrence L	Chesterfield	215
Crie, J. Stanley	St. Joseph	030
Crighton, John C	Springfield	082
Crighton, Kent A	Ballwin	166
Crighton, M. Nanette	Springfield	082
Criscione, James S	St. Louis	190
Criscione, James R, Sr.	St. Louis	190
Criscione, James R, Jr.	St. Louis	190
Crisp, N. Denney	Independence	002
Crist, Charles L	Cape Girardeau	042
Crist, Roderic C	Cape Girardeau	042
Critchlow, J. Thomas	Mexico	014
Critchlow, Michael E	Columbia	026
Critchlow, Wm C	Sikeston	202
Crockett, James E	Kansas City	125
Croll, Gregory H	Columbia	026
Cronemeyer, Richard L	Leawood	125
Crosby, William H	Joplin	102
Crotty, John P	St. Louis	190
Crouch, John A	Columbia	026
Croughan, Jack L	St. Louis	190
Crow, Martin L	Kansas City	125
*Crowell, Tamara E	Kansas City	215
Crowley, Wm J	Columbia	026
Crumpacker, Margaret	St. Louis	190
Cruz, Sergio G	Monett	166
Csaki, Bela	Independence	125
Cubillo, Enrique	Chesterfield	190
Cuddihee, Robert E	St. Louis	190
Culver, Perry J, Jr.	Kansas City	125
Cummings, James M	St. Louis	190
Cummings, Kenneth C	Kansas City	125
Cummings, Steven W	Brentwood	215
Cundiff, H. Clay	Independence	125
Cunningham, D. Dean	Springfield	082
Cunningham, Edwin J	Chesterfield	190
Cunningham, Milamari A	Columbia	026
Cunningham, R. Raymond	Columbia	026
Cunningham, Richard D	Springfield	082
Cunningham, William F	Springfield	082
Cupp, Gerald V	Columbia	026
Cupples, Tommy E	Cape Girardeau	042
Curnow, Richard B	Liberty	050
*Curran, Donald J	Rolla	135
Curran, Terrence	Kansas City	125
Curry, Denise T	Florissant	190
Curry, Michael J	St. Charles	189
Curry, Michael D	Columbia	026
Curtis, Jack J	Columbia	026
Custer, Galen M	Kansas City	125
Cusumano, Joseph V	St. Louis	190
Cusworth, Robert	St. Charles	189
Cutler, Harold M	St. Louis	190
Cygan, Ronald W	Kansas City	125
Cyriac, George K	Mexico	014
Czebrinski, Edward W	Chesterfield	190

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Daake, John W, Jr.	St. Louis	190
Daake, John W, Sr.	St. Louis	190
Dabbs, Wilbur D	Neosho	166
Dacey, Ralph G, Jr.	St. Louis	190
Dagartzikas, A K	St. Louis	190
Dahm, Chas H, Jr.	St. Louis	190
Daily, James M	Springfield	082
Daley, Frank R	Hamilton	078
Dalton, Arthur R	St. Louis	190
Dalton, Timothy T	Kansas City	125
Daly, James W	Columbia	026
Dames, Richard J	St. Louis	190
Dandridge, Walter C	Joplin	102
Danforth, Wm H	St. Louis	190
Dang, Phung T	St. Louis	190
Dang, Robert C	Pleasant Hill	214
Daniel, A E	Columbia	026
Daniels, John S	St. Louis	002
Danielsson, Ernst P	Springfield	082
Danis, Richard K	St. Louis	190
Dankner, Arnold	Chesterfield	190
Dankner, Rand E	Chesterfield	190
Danner, Shavonne L	Kansas City	125
Darnell, Dale E	Kansas City	125
Darnell, Thos F	Branson	026
Dash, Udaya N	Ft. Myers Beach	190
Daskalov, Zhivko	Kansas City	125
Datta, Narendar K	St. Louis	190
Daum, Harold F	Sedalia	178
Daus, Arthur S	Joplin	102
Davault, Geo K	Richmond	118
Davidner, Mark L	Kansas City	125
Davidson, Kendrick C	Leawood	125
Davidson, Morris	St. Louis	190
Davidson, Raymond P	St. Louis	190
Davis, Alexander C	Kansas City	125
Davis, Carl S	Lee's Summit	125
Davis, Charles S	Galena	102
Davis, Donald R	Overland Park	125
Davis, Ernest E	Fenton	190
Davis, Gene L	St Louis	190
Davis, Herbert V	Kansas City	125
Davis, J. Lawrence	St. Louis	190
Davis, Jack M	Kansas City	125
Davis, Kimberly M	Kansas City	215
*Davis, Larry E	Kansas City	050
Davis, Leonard L	Mexico	014
Davis, Mary A	St. Louis	190
Davis, Sheldon	Florissant	190
Davis, Thomas N	Mountain View	138
Davis, W. Bob	Overland Park	125
Davis, Wm E	Columbia	026
Davisson, Walter F	Jefferson City	058
Davuluri, Sreenadha R	St. Joseph	030
Day, Chester L	Prairie Village	125
Dean, Philip D	Washington	074
Dean, Walter E	Maryville	158
Deane, Louis V, Jr.	St. Louis	190
Deardeuff, Dwight L	Rolla	135
Decanini, Mario	St. Joseph	030
Deckard, Shelby W	Springfield	082
Decker, Albert I	Springfield	082
*Deffenbaugh, Larry D	Joplin	102
Dehner, Jonathan D	St. Louis	190
Dehner, Louis P	St. Louis	190
Dehning, Doug O	Independence	125
Del Pizzo, Ferdinand	St. Charles	189
Del Priore, Lucian V	St. Louis	002
Del Rosario, Horacio O	Chesterfield	190
Del Valle, Fernando	Chesterfield	190
*Delaney, Adrain J, Jr.	Kansas City	125
Delcambre, Marie A	Kansas City	125
Deleste, Carlos J	Festus	106
Deligeorges, John	Kansas City	050
Dell, Robert V	Hannibal	150
DelSanto, Peter B	Columbia	026
Dembinski, David R	Kansas City	125

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Dement, Oman E	102	Joplin
Demmy, Todd L	026	Columbia
Dempsey, Herbert A	125	Lee's Summit
*Dempsey, Herbert E	125	Lee's Summit
Dempsey, Kenneth J	202	Sikeston
Dempsey, Maureen E	026	Columbia
Denes, Bela	190	Bridgeton
Denk, Alan F	190	St. Louis
Denninghoff, James C	026	Columbia
Denninghoff, James S	026	Columbia
Dent, George W	138	Farmington
Desio, Marcus A	102	Joplin
Destouet, Judy	190	Baltimore
Dettmer, Robt F	138	Ironton
Devabhaktuni, Rama Devi	190	Ballwin
Dever, Robert L	102	Joplin
Devine, John B	190	St. Louis
Devine, Mark W	050	N. Kansas City
Devineni, V. Rao	190	St. Louis
Devins, George S	125	Kansas City
Devins, Sidney S	002	Kansas City
Devkota, Jagadishwar	026	Columbia
Dew, Thomas A	190	Chesterfield
Dewald, Paul A	190	St Louis
Dewein, Edward G	190	St Louis
Dexheimer, Frank R	026	Columbia
Dexter, J. Kent	082	Springfield
Dexter, James D	026	Columbia
DeBoard, James W	190	St. Louis
DeCastro, Fernando J	138	Viburnum
DeCoursey, Kenneth A	042	Cape Girardeau
DeFelice, Charles E	042	Cape Girardeau
DeFeo, Frederick G	125	Kansas City
DeFeo, Theodore C	125	Kansas City
DeGenova, Gerard H	174	Ste. Genevieve
DeGraff, Judith K	215	Mission
DeGuerre, Ronald K	190	Chesterfield
DeLeeuw, Karel A	082	Springfield
DeLine, Jim	046	Macon
DeMotte, Jeanne M	118	Richmond
DePriest, Michael D	030	St. Joseph
DeRosa, Michael J	190	St. Louis
DeSilva, Ananda	190	Hazelwood
DeSpain, John D	026	Columbia
DeUngria, Pablo C	190	Bridgeton
DeVera, Anson E	190	St Louis
Dick, Earl	026	Columbia
Dick, M. Marga	026	Ashland
Diedriech, Linda L	190	St. Louis
Diehl, Antoni M	125	Lenexa
Diehl, Elizabeth W	190	St. Louis
Diemer, David P	190	St. Louis
Diemer, Jean	042	Cape Girardeau
Diemer, Peter A	190	St. Louis
Diemer, Thomas S	042	Cape Girardeau
Dierberg, Dale F	074	Chesterfield
Dierker, Harry D	026	Columbia
Diestelhorst, James A	190	St. Louis
Dieterich, Russell B	189	St. Charles
Dihenia, Bhupesh H	215	Kansas City
Dill-Wilkinson, Linda	125	Kansas City
Dillard, Burl M	190	St. Louis
Dillard, Erin M	082	Springfield
Dills, Joseph N	082	Rolla
Dilts, Preston V, Jr.	125	Kansas City
Dilworth, Jacquelyn B	190	St. Louis
Dimayuga, Nestor G	206	Mansfield
Dinkins, James A	042	Cape Girardeau
Ditmore, Q. Michael	026	Columbia
*Ditzel, Douglas W	102	Joplin
Divelbiss, Karen L	215	Kansas City
Dix, Patricia M	082	Springfield
Dixon, Druery J	206	West Plains
Dixon, Geo D	125	Kansas City
Dixon, Herbert K	102	Joplin
Dixon, John R	078	Brookfield
DiFilippo, Emil A	189	St. Charles
DiPasco, Donald J	190	St. Louis
Dlabal, Luke J, Sr.	125	Independence
Dlabal, Luke J, Jr.	125	Independence
Dmytryk, Eugene T	190	St. Louis
Doan, Laura B	125	Raytown
Docherty, Martin A	215	Kansas City
Dodge, Philip R	190	St Louis
Doerhoff, Adelia L	058	Jefferson City
Doerhoff, Alan R	058	Jefferson City
Doerhoff, Carl R	058	Jefferson City
Doerr, Dale E	190	St. Louis
*Dohanich, John P	042	Jackson
Doisy, Philip P	190	St. Louis
Dolan, Patrick H	190	St. Louis
Dolan, Renee C	190	Chesterfield
Domann, Darrel D	082	Springfield
Domke, Henry F	058	New Bloomfield
Donahoe, James L	190	Clayton
Donati, Robert M	190	St. Louis
Donnell, Harold E	106	De Soto
Donnell, Robt H	106	Crystal City
Donnell, William S, Jr	066	Bolivar
Donovan, John F	190	St Louis
Donovan, Thomas J	190	St Louis
Dooley, Joseph M, Jr.	190	St. Louis
Dorsch, Ervin H	125	Independence
Dorsch, Stephen E	125	Independence
Dorton, Robert K	190	St. Louis
Dorzab, Linda L	125	Overland Park
Dorzab, William E	125	Kansas City
Dos Santos, Enrique	026	Columbia
Dotson, Rachel L	215	Columbia
Douglass, Eric J	050	Gladstone
Dowell, Geo H	190	St Louis
Downey, James W	125	Mission
Downey, Jon P	042	Cape Girardeau
*Downing, Gregory J	125	Shawnee
*Downs, Craig E	082	Springfield
Downs, Daniel M	125	Kansas City
Downs, Mary K	082	Springfield
Doyle, Chas R	190	St Louis
Drabinowicz, Sallie E	082	Springfield
Drake, Avery A	135	Scottsdale
Drake, Roy F	125	Mission
Drake, William L, Jr.	190	St Louis
Draney, Thos E	125	Hiwasse
Dreher, Richard L	125	Leawood
Drescher, Emmett B	190	St. Louis
Drews, Robt C	190	St Louis
Dreyer, Carl J	190	St. Louis
Dreyer, Philip V	046	Huntsville
Dreyer, Wm F	206	Houston
Driks, Michael R	125	Kansas City
Drisko, Jeanne A	125	Prairie Village
Drisko, Robert M	125	Kansas City
Drisko, Robert M, II	125	Kansas City
Drozda, Joseph P, Jr.	190	Bridgeton
Druck, Norman S	190	Chesterfield
Druet, Robert L	082	Springfield
Dubin, Sol H	125	Independence
Duda, Ralph J, Jr.	082	Springfield
Dudik, Randall G	030	St. Joseph
Dueker, David K	026	Columbia
Duello, Deborah K	125	Independence
Duemler, Robt H	190	Glenco
Duensing, George F	082	Springfield
Duer, Mildred C	125	Kansas City
Duerksen, Joseph J	125	Kansas City
Duff, James E	082	Springfield
Duff, William M	135	Rolla
Duffy, Francis G	190	St. Louis
Duffy, Oliver F	078	Trenton
Dugan, Gerald F	125	Kansas City
Duggan, Eileen D	002	St. Louis
Dugger, David E	190	St. Louis
Duick, Daniel S	042	Cape Girardeau
Dukstein, Walter G, Jr.	125	Kansas City
Duling, Gerald J	189	St. Charles
Dumadag, Virgilio P	190	St Louis
Dumadag-Sabio, Maria C	002	St. Louis
Duncan, David T	189	St. Peters
Duncan, Douglas M	082	Springfield
Duncan, Robt D	082	Springfield

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Duncan, Wm H	Naples	125
Dunlap, Michael D	St. Joseph	030
Dunn, Charles W	Springfield	082
Dunn, David B	Liberty	050
Dunn, Melanie A	Kansas City	125
Dunn, Robert C, Jr.	St. Louis	190
Dunshee, Robt E	Maryville	158
Dunteman, Edwin D	Manchester	215
Durel, Justin H	St. Louis	190
Durham, Ms. Tracy	Hayti	001
Durnell, Monaford D	Kansas City	125
Durr, Jon W	Florissant	190
Dusek, Dennis A	St. Louis	190
Dusing, Reginald W	Kansas City	215
DuMont, Clement C	St. Joseph	030
DuMontier, Alan J	Chesterfield	190
DuMontier, Edward H	Farmington	138
Dwyer, Frank X	Shawnee Mission	125
Dwyer, James G	St. Louis	190
Dyer, Curtis W	Warrensburg	110
Dyer, Dallas J	St. Louis	190
Dyer, Gary A	St. Joseph	030

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Eachempati, Rama G	Puyallup	190
Eachempati, Uma R	Arnold	190
Eades, Joseph W	Chesterfield	190
Early, Gerald L	St. Joseph	030
Earnest, James B	Kansas City	125
Eaton, Paula	Kansas City	125
Ebelke, David K	N. Kansas City	125
Eberle, Vincent L	St. Louis	190
Eckenrode, James F	Columbia	026
Ecker, Desider B	Sun City Ctr	190
Eckert, Clarence T	Longboat Key	190
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Edele, Eugene H	St Louis	190
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Edmisten, Jack	Nevada	125
Edmonds, Robt W	Chesterfield	002
Edwards, Charles F	Moberly	046
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Edwards, Theodore F	Kansas City	050
Edwards-Garland, Shelley J	Kansas City	125
Egan, Robert C	St. Louis	190
Egan, Thos F	St Louis	190
Egbert, Robert N	Springfield	082
Eggers, George W, Jr.	Columbia	026
Eggleston, Harry C	St. Louis	190
Eggleston, Thomas F	St Louis	190
Ehlert, Tamara K	St. Louis	190
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Eliasson, Sven G	St. Louis	190
Elkins, Robert L	Kansas City	125
Eller, Gordon W	Cape Girardeau	042
Ellfeldt, Howard J	Kansas City	125
Elliott, Raymond G	Shawnee Mission	125
Elliott, Wade E	Kansas City	125
Elliott, Wendell H	Poplar Bluff	034
Ellis, Francis J	Springfield	082
Ellis, Harry L	Springfield	082
Ellis, Jean H	Blue Springs	125
Ellis, John C	Independence	125
Ellis, Ronald L	Springfield	082
Ellsasser, James C	Rocheport	026
Elser, Otto H	Independence	125
Ely, Norman B	Springfield	082
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Estrem, Scott A	Columbia	026
Eto, Jackson K	St. Louis	190
Ettelson, Charles D	Chesterfield	190
Eubank, David F	Lee's Summit	125
Eubank, Wm Y	Leawood	125
Evans, Andrew L	Springfield	082
Evans, Charles	Jefferson City	058
Evans, Ezra L	Springfield	082
Evans, George A	Columbia	026
Evans, Joseph M	Hannibal	150
Evans, Joseph C, Jr.	Independence	125
Evans, Lawrence L	Kansas City	125
Evans, Lawrence G, Jr.	St Louis	190
Evans, Maria L	Columbia	215
Evens, Ronald G	St Louis	190
Eversoll, Norton J	Hollywood	190
Every, Pamela D	Cape Girardeau	042
Ewigman, Bernard G	Columbia	026
Ewing, Lesley L	Kansas City	125
Exon, C S	Jefferson City	058
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Fairchild, Ralph B	St. Louis	190
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Farthing, Gene W	Springfield	082
Farzana, Farida	St. Louis	190
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Faszholz, Mark S	St. Louis	190
Fathman, Anthony E	Chesterfield	190
Favazza, Armando R	Columbia	026
Favors, Adolphus C, Jr.	St. Louis	190
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Feller, Harold H	Chesterfield	190
Ferber, Alan J	Kansas City	125
Ferguson, John F	Springfield	082
Ferguson, John L	Springfield	082
Fernandez, Fernando	St. Joseph	030
Fernandez, Mark A	Platte City	125
Ferneau, James E	Columbia	026
Ferns, Francis E	Kansas City	125
Ferrara, Robert P	St. Louis	190
Ferrari, Herbert A	St. Louis	190
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Ferris, Carl R	Overland Park	125
Ferris, Charles W, Jr.	St. Louis	190
Ferris, Robert E	Jefferson City	058
Ferry, Richard J	St. Louis	190
Fibuch, Eugene E	Kansas City	125
Figueroa, Eliseo O	St Louis	190
Fingert, Hyman H	St Louis	190
Fink, Leroy L	St. Louis	190
Fink, Roger L	Springfield	082
Finkel, Barney W	N. Ft. Myers	190
Finley, John M	Joplin	102
Finn, Murray E	St Louis	190
Finnegan, Jos V	St Louis	190
Fiore, Andrew C	St. Louis	190
Fischbein, Lewis C	St. Louis	190
Fischer, Edward H	Gladstone	050
Fischer, John R	Hermann	190
Fischer, Robert	St. Louis	190
Fisher, James K	Kansas City	125
Fisher, Jos L	St. Joseph	030
Fisher, Linda	St. Louis	190
Fisher, Mary Jo	Springfield	082
*Fisher, Robert B	Columbia	026
Fishman, Norman	Chesterfield	190
Fitch, Coy D	St. Louis	190
Fitz, John R	Farmington	138
Fitzmaurice, Laura S	Kansas City	125
FitzSimmons, James G	Kansas City	125
Fivian, Gerald J	St Louis	190
Flance, Israel J	St Louis	190
Fleming, Allan R	Kansas City	125
Fleming, David A	Moberly	046
Fleming, J. Will , Jr	Moberly	046
Fleming, Robt J	St. Charles	189
Fleshman, James W	St. Louis	190
Fletcher, James L, Jr.	Cape Girardeau	042
Fletcher, Robert C	Kansas City	125
Fletes, James W	St Louis	190
Flicker, Michele R	Kansas City	125
Florence, Kerry E	Washington	074
Florendo, Federico N	Hannibal	150
Florendo, Purificacion T	Hannibal	150
Flores, Jhonson E	St. Louis	190
Floro, Kenneth E, Jr.	St. Louis	190
Floro, Mariano N	Florissant	190
Flotte, Sylvester A	St Louis	190
Floyd, Marla J	Springfield	082
Flug, Eric J	St. Louis	190
Flury, Kirk E	St. Louis	190
Flynn, James M	Kansas City	125
Flynn, John T	St Louis	190
Fogarty, William M, Jr.	St. Louis	190
Fogel, Steven T	Leawood	215
Fogle, Philip R	Springfield	082
Folck, Wm P	Kansas City	125
Foley, Jonathon K	Cape Girardeau	042
Folkner, Albert L	Warrensburg	110
Foote, Daniel D	Springfield	082
Foote, Jerry E	Columbia	026
Forand, Joseph M	St. Louis	190
Ford, Lee T	Belleville	190
Ford, Thomas E	Niagara Falls	190
Foreman, Phillip B	Hannibal	150
Forgue, Donald R	Kansas City	125
Forman, Louis H	Shawnee Mission	125
Forman, Mary R	Kansas City	125
Forsman, Karen E	St. Louis	190
Forsman, Waldo W	St Louis	190
Forsyth, B. Todd	St. Louis	190
Forsythe, Lees C	Shawnee Mission	125
Forsythe, Robert W	Shawnee Mission	125
Fortin, Don G	Kansas City	050
Fortin, Jorge A	Rolla	135
Foster, R. Steve	Sedalia	178
Fotopoulos, Chris K	DeQueen	120
Fouts, Dallas B, Sr.	Independence	125
Fowler, Fred D	Kansas City	125
Fowler, I. Charles	Sun City Center	050
Fowler, James W	Leawood	125
Fowler, Marvin L	West Plains	206
Fowler, Wayne L, Jr.	Kansas City	125
Fox, Gerald E	St. Joseph	030
Fox, Robert E	Chesterfield	190
Fox, Thomas J	St. Louis	190
Fracasso, Paula M	St. Louis	002
Francel, Thomas J	St. Louis	002
Francis, Roger A	Osage Beach	120
Francisco, Clarence B	Kansas City	125
Francisco, Dominic S	St. Louis	190
Frank, Gael R	N. Kansas City	125
*Frank, Robert A	Kansas City	125
Franklin, Harold A	St Louis	190
Fraser, Daniel M	St Louis	190
Fraser, Victoria J	St. Louis	190
Frawley, Thomas F	St. Louis	190
Frazier, Robt E	Columbia	026
Frazier, Robt L	Sikeston	202
*Frederick, Mark R	Jefferson City	058
Frederick, Raymond O	St. Louis	190
Frederickson, Neil W	St. Louis	190
Freedman, Ruth S	Clayton	190
Freeman, James A	Columbia	026
Freeman, Jerry C	Kansas City	125
Freeman, Mark E	St. Louis	215
Freeman, Michael R	Cape Girardeau	042
Freiden, Floyd J	Kansas City	125
Freiman, Paul C	Springfield	082
Frein, Donald E	Harrisonville	214
French, M. Devonne	Lee's Summit	125
Frerking, Ex. Dir., Darren	Kansas City	001
Frevert, Larry F	Kansas City	125
Frewin, Paul R	Springfield	082
Frey, Jeffrey P	Columbia	026
Fried, John S	Overland Park	125
Friedman, Michael J	Leawood	125
Friedman, Morris L	Shawnee Mission	125
Friedman, William H	St. Louis	190
Friedrich, Anthony P	St. Peters	190
Friend, T. Gregory	Kansas City	125
Fries, John W	St. Louis	190
Friesen, Randall G	St. Charles	189
Fritsch, Andrew J	Joplin	102
Fritz, William H	St. Louis	215
Fritzlen, Thos J	Overland Park	125
Froehlich, Thomas W	Springfield	082
Froeschle, Ellis Birch	Rocheport	215
Frogge, Jim D	Joplin	102
Frohman, Boris	Sikeston	202
Fromme, Glenn A	Springfield	082
Frumson, Guy H	Florissant	190
Fry, Robert D	St. Louis	190
Fuchs, Geo J	Columbia	026
Fuhrman, Donald L	Shawnee Mission	125
Fuleihan, Farid M	St. Louis	190
Fulks, Richard B	California	058
Fuller, Terry A	St. Louis	190
Funsch, Robert E	St Louis	190
Furla, August J	St Louis	190
Furlong, Lawrence D	Kansas City	125

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Gabel, Michael G	St. Louis	190
Gadson, Michael T	Hannibal	150
Gaffney, Laura A	Kansas City	215
Gafford, Franklin H, IV	St. Louis	190

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Gagliardo, Joseph	St. Louis	190
Gaines, Robert W	Columbia	026
Gainor, Barry J	Columbia	026
Gaitonde, Mangesh R	Lee's Summit	026
Galakatos, Andrew E	Chesterfield	190
Galant, Mark R	Belton	125
Galblum, Larry I	Kansas City	125
Gale, Arthur H	St. Louis	190
Gale, Joseph F	Chillicothe	078
Galindez, Orlando A	Kansas City	215
Gall, Clifford M	Kansas City	125
Gall, Ira C	St. Louis	190
Gallion, Terry L	Prairie Village	002
Galvez, Sisenando P	Marceline	078
Gans, Lawrence A	Florissant	190
Gansloser, Wilbert M	Clayton	190
Gantz, John A	St. Louis	190
Garcia, Delia M	St. Louis	190
Garcia, Eduardo L	St. Louis	190
Garcia, Kathleen M	Clayton	190
Garcia-Ferrer, Eduardo A	Miami	190
Gardner, Joe A	Joplin	102
Gardner, Jos W	Kimberling City	166
Garfinkel, Bernard T	St. Louis	190
Garfinkel, Lester S	Kansas City	125
Garmager, Kirk K	Overland Park	215
Garner, Royal S	St. Petersburg	058
Garrard, Jacqueline M	St. Louis	215
Garrett, Elizabeth A	Columbia	026
Garrett, Ted E	St. Louis	190
Garrett, Exec VP, G. R.	St. Louis	001
Garriga, Francisco J	Florissant	190
Garrison, Carla J	Springfield	082
Garrison, David L	St. Joseph	030
Garrison, Roy F	Kansas City	125
Garrison, Theodore W	Camdenton	120
Garrotto, Lewis J	Columbia	026
Garvin, Charles F	St. Louis	190
Garvin, Paul J	St. Louis	190
Gaskin, Fred W	St. Louis	190
Gassman, Ann A	Kansas City	125
Gatchalian, Felicitas Z	St. Louis	190
Gates, George A	St. Louis	190
Gauer, Robt J	Kansas City	050
Gauthier, Charles P	Kansas City	125
Gavankar, Sharad S	Joplin	102
Gavini, Rajendra R	St Louis	190
Gay, John W	Columbia	026
***Gayle, David R**	Piedmont	034
***Gayle, Richard E**	Piedmont	034
Gearhart, Wilbur H	Chesterfield	190
Gedney, Wm B	Valley Park	190
Gehm, Louis E	Butler	214
Geise, August W	Chesterfield	190
Geisman, Richard A	St. Peters	189
Geisse, Guillermo	St. Louis	190
Geller, Bruce D	Kansas City	125
Gellman, Elliot F	St Louis	190
Gelstein, Laurence D	St. Louis	190
Gemperli, Amy W	Leawood	215
Gendel, Jonathan	Lee's Summit	002
Gennaoui, Jad M	St. Louis	190
Gentry, Jim	Springfield	082
Gentry, Marvin C	Ava	206
Gentry, Michael A	Springfield	082
Gentsch, Kenneth W	St. Louis	190
George, Philip G	St Louis	190
Geraghty, Thomas E	Kansas City	125
Gerard, James M	St. Charles	215
Gerdes, John A	Springfield	082
***Gerdes, John M**	Chesterfield	190
Gerdes, K. Eric	Springfield	082
Gerecht, Wolfe B	Springfield	082
Gerhardt, Donald C	Columbia	026
German, Walter A	Springfield	082
Germann, Donald R	Shawnee Mission	125
Gernstetter, S L	Poplar Bluff	034
Gerowin, Lance	St. Louis	190
Gerst, Aloysius C	St. Louis	190
Gessler, James A	Springfield	082
Geter, Rodney K	Springfield	082
Gettel, Ann H	Kansas City	002
Geurkink, John W	Joplin	102
Gholkar, Vijay R	Kansas City	125
Ghosh, Nellie	St. Louis	190
Giangiacomo, Joseph	Columbia	026
Gibb, Randall K	St. Louis	215
Gibbons, James J	St. Louis	190
***Gibbons, Jerry L**	St. Louis	190
Gibbons, Robert T, Jr.	Overland Park	125
Gibson, David M	Santa Fe	125
Gibson, James D	Springfield	082
Gibson, Merlyn D	Columbia	026
Gibson, Paul H	St. Louis	190
Gibson, William P	Chesterfield	190
Gibson, Exec Dir, Lee	Columbia	001
Giddings, Frank C	Springfield	082
Gieselmann, James W	Poplar Bluff	034
***Giffen, Lawrence E**	Jefferson City	058
Gilbirds, William M, II	Kansas City	050
Gilden, Jerome J	St. Louis	190
Gile, Robert J	Cape Girardeau	042
Gill, Paul J	Springfield	082
Gillbanks, Marjon M	Independence	125
Gilula, Louis A	St. Louis	190
Gimpelson, Richard J	Chesterfield	190
Ginardi, Donald E	Kansas City	125
Ginsberg, B. William	Kansas City	125
Ginsberg, Fred B	St. Louis	190
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Giorgi, Lee V	Kansas City	125
Gish, E R	Fulton	038
Givler, Robt L	Kansas City	125
Gladney, John H	St Louis	190
Glaser, Larry F	Cleveland	125
Glass, James M	Columbia	026
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Goebel, Joan M	St. Louis	190
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Goetz, Joseph J	Overland Park	125
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Goheen, John R	Kansas City	125
Gold, Jonathan A	St. Louis	190
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Goldfarb, Alvin	St. Louis	190
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Gordon, James M	Florissant	190
Gordon, James S	Jefferson City	058
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Gose, Don F	Springfield	082
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Luther, George A	St. Louis	190
Lutkewitte, Jos F	Ste. Genevieve	174
Luzecky, Michael H	Springfield	082
Lyddon, Harold R, Jr.	Kansas City	125
Lyle, Robt R	Versailles	120
Lyles, Rodney	Overland Park	125
Lyman, Edward H	St Louis	190
Lynch, James M	Joplin	102
Lynch, Thos W	Springfield	082
Lyons, Daniel F	Springfield	082
Lyskowski, John C	Jefferson City	058
Lyskowski, Maria M	Jefferson City	058
Lyss, Carl A	St. Louis	190
Lyss, Stanley B	St Louis	190
Lytle, Edwin L	St. Louis	190
Lytle, Michael F	Shawnee Mission	125

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Maben, Sam E	Kansas City	125
Macdonnell, Thos M	Marshfield	210
Machefsky, Sidney D	St. Charles	190
Machek, Otakar	St Louis	190
Mackey, Richard L	St. Louis	002
Macleod, Angus	St Louis	190
Macler, Henry H, Jr.	St. Louis	190
Macnish, James M	St Louis	190
MacDonald, Robt R, Jr.	St. Louis	190
MacDonald, Wm C	St Louis	190
MacGee, Edwin E	Kansas City	125
MacKinnon, Susan E	St. Louis	190
MacLaughlin, James C	Joplin	102
MacNaughton, Ralph E	Kansas City	125
MacNaughton, Robert A, II	Liberty	050
MacNaughton, Robert A	Kansas City	125
Madaj, Debra K	Kansas City	125
Madden, Michael L	Kansas City	125
Maddipati, Sreedevi	St. Louis	190
Madduri, Aruna D	Poplar Bluff	034
Madduri, Sivaprasad D	Poplar Bluff	034
Madlang, Rudy G	Columbia	026
Madrid, Dominador O	St Louis	190
Magaw, David C	Everton	066
Magee, Robt L	Eldorado Sprgs.	214
Magee, W. Edwin	Imperial	190
*Magill, William S	Springfield	082
Magruder, Lyell M	Nevada	214
Mahboubi, Aziz O	Sikeston	202
Maher, Robt W	Springfield	082
Mahnken, Robert F	Springfield	082
Mais, Thomas E	Shawnee Mission	125
Maitz, Carlos A	St. Ann	190
Major, Troy E	Springfield	082
Majors, Patrick F	St. Louis	190
Majzoub, Hish S	Joplin	102
Makos, Mignon M	St. Joseph	030
Malkoff, Marc D	St. Louis	190
Mallouk, Alexander G	Kansas City	125
Mallow, James E	Kansas City	125
Malmberg, Virgil L	Chesterfield	190
Maloney, Robert M	St. Louis	190
Maminta-Streiff, Maria G	St. Louis	190
Manansala, Antonio Q	St. Louis	190
Mandler, George	Chillicothe	078
Mangalat, Narayanan K	Joplin	102
Mangum, William B	Independence	125
Mangunta, Vijaya K	New Madrid	202
Mani, Mary E	Clayton	215

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Manion, Thos S	Independence	125
Manire, John E	Joplin	102
Mann, James K	Hannibal	150
Mann, Rodney M	Kansas City	215
Mannis, Charles I	St Louis	190
Manske, Paul R	St. Louis	190
Mantell, Jack M	Springfield	082
Mantese, Vito A	St. Louis	190
Mantovani, John F	St. Louis	190
Maple, Francis M	Springfield	082
Maranan, Diosdado L	Arnold	106
Maravilla, Levy M	St. Louis	190
Marbarger, John P, Jr.	St. Louis	190
Marchiando, Albert W	Washington	074
Marchosky, J. Alex	Chesterfield	190
Marcus, Michael D	St. Louis	190
Marcus, Morris D	St. Louis	190
Mardelli, Pierre G	Mission	215
Mardini, Edward E	Bonne Terre	138
Margolis, David M	St. Louis	190
Margolis, Robert P	St. Louis	190
Marietta, William G	Cape Girardeau	042
Markway, Gregory A	Independence	125
Marr, Garrett L	Kansas City	125
Marrs, David B	St. Charles	189
Marsh, Alice	Pleasant Hill	125
Marsh, Jeffrey L	St. Louis	190
Marshall, Hal E	Kansas City	125
Marshall, Jay P, II	Chesterfield	190
Marshall, Nyron T	Kansas City	215
Marshall, William G	Glasgow	026
Marshall, William H	Jefferson City	058
Marston, F. James	St. Joseph	030
Marti, Larry B	Rolla	135
Martin, Chris J	Columbia	026
Martin, Clarence A	Joplin	102
Martin, Daniel J	St. Louis	190
Martin, David S	Chesterfield	190
Martin, Jeffrey W	Bridgeton	190
Martin, John N	St. Joseph	030
Martin, Mark W	Lee's Summit	125
Martin, Richard A	Cape Girardeau	042
Martin, Robert A	West Plains	206
Martin, Scott A	Chesterfield	190
Martin, Stanley B	St. Charles	215
Martinez, Kimberly R	Kansas City	215
Marty, David R	Jefferson City	058
Martz, John C	St. Louis	190
Marvin, Robert D	Kansas City	215
Marzek, Peter A	St. Louis	002
Maslan, Mark J	Kansas City	125
Mass, Joan H	Florissant	190
Massey, Vickie	Kansas City	125
Masters, Edwin J	Cape Girardeau	042
Masters, Wm H	St. Louis	190
Mathew, Ruby	Chesterfield	190
Mathews, Jeffrey E	St. Louis	215
Matile, Gerald U	Kansas City	125
Matovich, Violet B	Kansas City	125
Matson, Jeffrey A	Kansas City	125
Matta, Camille S	Kansas City	125
Mattax, James B, Jr.	Springfield	082
Matthews, J. Mark	Kansas City	125
Matthews, John I	Jefferson City	058
Matthews, John G	St. Louis	190
Matthews, Richard H	Rolla	135
Matthews, Thomas D	Washington	074
Maughs, Sydney B	St Louis	190
Mauldin, Charles C	Springfield	082
Maupin, Kathy C	Florissant	190
Maves, Michael D	St. Louis	190
Maxson, Katherine A	Chesterfield	190
Maxson, Theodore R	Warrensburg	110
May, Albert L	Poplar Bluff	034
Mayer, John H, Jr.	Kansas City	125
Mayer, Lawrence M	Cape Girardeau	042
Mayer, Robt A	Pocono Pines	190
Mayes, Ben R	St. Louis	190
Maylack, Fallon H	Florissant	190
Maynard, Colleen M	Kansas City	125
Mayuga, Edgardo G	St. Louis	190
Mayuga, Laureano G	Cabool	206
Mayus, Joseph L	Springfield	082
McAdam, C. Rush	St. Louis	190
McAfee, Gordon	Springfield	082
McAlhany, Howard J	Springfield	082
McBride, Lawrence R	St. Louis	190
McCabe, Eugene J	St. Charles	189
McCadden, Michael E	St. Louis	190
McCaffree, Mary K	Jefferson City	058
McCalla, John P	Kansas City	050
McCallister, Ben D	Kansas City	125
McCanse, Andrew	N. Kansas City	125
McCanse, Lynn R	N. Kansas City	050
McCarthy, Christopher	St. Louis	190
McClennan, Bruce L	St. Louis	190
McCluggage, Newton C	N. Kansas City	050
McConahay, David R	Kansas City	125
McConchie, James E	Lee's Summit	125
McCool, James F	St. Louis	190
McCorcle, Marcus D	Springfield	082
McCord, E. Scott	Columbia	026
McCormack, Robert E	Kansas City	125
McCormick, James E	Kansas City	050
McCown, Allan H	St. Louis	190
McCoy, Frederick J	Kansas City	125
McCray, Glen M	Springfield	082
McCray, Stephen A	N. Kansas City	050
McCroskey, Brian L	Kansas City	125
McCroskey, Lon C	Kansas City	125
McCullough, Joseph E	Kansas City	125
McCullough, Timothy L	Chesterfield	002
McDavid, Robert E	Columbia	026
McDermott, Alfred E	Perryville	174
McDonald, Herbert L	Bolivar	002
McDonald, Margaret E	Joplin	102
McDonald, Michael G	Joplin	102
McDonald, Wallace	St. Joseph	030
McDonald, Wilbur P	St. Joseph	030
McDonnell, John F	Kansas City	125
McElroy, Glenn L	Columbia	026
McFadden, Gene A	Waverly	118
McFarland, Rodney J	Neosho	166
McGinnis, Wm F	Chesterfield	190
McGinty, Chas P	Cape Girardeau	042
McGinty, Frank H	Cape Girardeau	042
McGoff-Fahrner, Mari A	Webster Groves	002
McGonigle, James P	Joplin	102
McGonigle, Michael M	Joplin	102
McGovney, Janice K	Smithville	050
McGraw, James P	Kansas City	215
McGuire, Patricia A	St. Louis	190
McGuire, Thomas H	Shawnee Mission	125
*McIntire, Larry D	Joplin	102
McIntire, Timothy L	Jefferson City	058
McIntosh, Donald E	Kansas City	125
McIntosh, Douglas A	Cape Girardeau	042
McIntosh, Michele C	Independence	125
McIntyre, John D	Kansas City	125
McKeel, Thos B	Kansas City	125
McKinley, Lois J	Kansas City	125
McKinney, Daniel C	Springfield	082
McKinney, John W	St. Louis	190
McKinney, William D, Jr.	Belleview	138
McKinsey, David S	Kansas City	125
McKnelly, Wm V, Jr.	Kansas City	125
McKnight, Scott J	Liberty	050
McLaren, David L	Columbia	026
*McLaughlin, Dan A	St. Joseph	030
McLaughlin, Durnell	Kansas City	125
McLaughlin, Richard D	Springfield	082
McLemore, Willie O	Kansas City	125
McMeekin, Sheila P	Overland Park	125
McMillan, David L	Neosho	166
McMillen, James J	St. Joseph	030
McMillin, John N	Springfield	082
McMullin, Forbes A	St Louis	190
McMurray, Scott W	Springfield	082
McMurry, Ted A	Springfield	082
McNamara, John J	St. Louis	190

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McNeal, Douglas M	Springfield	082
McNitt, Jay D	Kansas City	125
McPhee, Mark S	Kansas City	125
McQueary, Frederick G	Springfield	082
McVey, Pamela S	Kansas City	125
Meadows, C. Douglas	St Louis	190
Mechlin, David C	Columbia	026
Medler, John F	St Louis	190
Medler, P. Louis	St Louis	190
Medlicott, William J	Port Townsend	125
Meegan, Robt J	Overland Park	125
*Meghjee, Zinnat	Olney	190
Mehaffy, Orville A	Joplin	102
Mehan, Donald J	St. Louis	190
Mehlhorn, Gary L	Springfield	082
Mehr, David R	Columbia	026
Mehra, Ravi	St. Louis	190
Meier, Francis X	Jefferson City	058
Meinberg, William H	North Ridge	190
Meiners, David J	St. Louis	190
Meiners, Paul N	St. Louis	190
Meiners, Theodore M	Chesterfield	190
Mejia, Victor E	Sikeston	202
Melberg, Nancy	Clayton	215
Meldi, Dominic M	Springfield	082
Melgaard, Sven R	Leawood	125
Melia, B J, Jr.	Kansas City	125
Mell, Roger L	Chesterfield	190
*Mellies, Steven D	Cape Girardeau	042
Meltz, Gary J	St. Charles	189
Memken, John A	Hannibal	150
Menchetti, Donald E	Springfield	082
Mendelsohn, George E	Chesterfield	190
Mendelsohn, Robert S	St. Louis	190
Mendonsa, Lawrence E	Chesterfield	190
Menne, Marvin C	Ironton	138
Mentel, John J	St. Peters	189
Mentgen, Carl N	Springfield	082
Meredith, William R	Joplin	102
Merenda, Frank J	St. Louis	190
Merenda, James T	St. Louis	190
Merenda, Sam J	St Louis	190
Merkel, Kurt D	St. Louis	190
Merkle, John A	St. Louis	190
Merritt, Burch A	St. Louis	190
Mertz, Janet S	Kansas City	125
Merys, Shawn C	Kansas City	215
Mestad, Peter H	Kansas City	125
Mestres, Hugh M	St Louis	190
Metry, Donald J, Jr.	Chillicothe	078
Metzler, Michael H	Columbia	026
Meyer, Jay L	St. Louis	190
Meyer, Jerry L	Concordia	118
Meyer, John W	Springfield	082
Meyer, John S	Chesterfield	190
Meyer, Joseph V	St. Louis	215
Meyer, Melvin E	St Louis	190
Meyer, Paul W	Shawnee Mission	125
Meyer, Randall E	Jefferson City	058
Meyer, Robert C	St. Louis	190
Meyer, Wayne W	Bridgeton	190
Meyerrose, Gary E	Lubbock	190
Meyers, Elsie F	St. Louis	190
Meyers, Jerry R	St. Peters	189
Meyers, John B	St. Louis	190
Meyers, Robert W	St. Louis	190
Meystrik, Rosellen S	Springfield	082
*Michael, Roy A	Jefferson City	058
Michael, Vernon E	St Louis	190
Michaelree, John F	Ballwin	190
Michaels, Robert H	Springfield	082
Michelson, Richard B	Kansas City	125
Middleton, Jerry N	Chesterfield	190
Middleton, Mary A	St. Louis	190
Miedema, Brent W	Columbia	026
Mihalevich, John A, Jr	Springfield	082
Milder, Barry D	St. Louis	190
Milder, Benj	St. Louis	190
Miles, Geo O	Shawnee Mission	125
Miles, Paul W	Chesterfield	190
Miles, Wayne B	Springfield	082
Milgram, Byron A	Kansas City	125
Mill, Wm B, Jr.	St. Louis	190
Miller, Charles W	St. Louis	190
Miller, Chas , Jr.	St. Louis	190
Miller, Dace L	Springfield	082
Miller, Donald	Jefferson City	058
Miller, Gayle P	Kansas City	125
Miller, Geoffrey W	St. Louis	190
Miller, Gerald L, Jr.	Kansas City	125
Miller, Harry G	Clinton	086
Miller, James E	St. Louis	190
Miller, John T	Kansas City	125
Miller, Joseph P	Cape Girardeau	042
Miller, Jule P	St Louis	190
Miller, Leroy J	Columbia	026
Miller, Michael R	Kansas City	125
Miller, Pamela S	Columbia	215
Miller, Robert N	St. Louis	190
*Miller, Robin C	Lake St. Louis	190
Miller, Suzanne L	Grover	190
Miller, William D	St. Joseph	030
Miller, Wilson H	Kansas City	125
Miller, Exec. Dir., Judy	Joplin	001
Millet, Ruth E	Kansas City	125
Mills, Melissa J	Shawnee Mission	002
Milne, Jay L	Springfield	082
Milster, Clyde R	St Louis	190
Miltenberger, Paul C	Columbia	070
Mink, Jonathan W	St. Louis	215
Minke, Thomas A	St. Louis	215
Minkoff, I. Monica	St. Peters	189
Minkovitz, Jeffrey	St. Louis	215
Minnigerode, Lana K	Kansas City	125
Minnigerode, Turner L	Kansas City	125
Mir, A. Rauf	Kansas City	125
Mirbaha, Mitchell M	St. Louis	190
Mirly, Harvey L	St. Louis	002
Mirowitz, Scott A	St. Louis	190
Mischnick, Carol R	Chesterfield	190
Mishkin, Marvin R	St Louis	190
Miskovsky, Emil F	Bridgeton	190
Missey, Wilburn C	Chesterfield	190
Mistry, Tehmton S	Chesterfield	190
Mitchell, Andrew D	Prairie Village	125
Mitchell, Franklin L	Columbia	026
Mitchell, John D	Kansas City	125
Mitchell, Lynn D	Columbia	026
Mitchell, Thos J	St. Clair	074
Mitchem, Olevia	Overland Park	125
*Mitchem, Randall E	Mission	058
Mitra, Nirmal K	Kansas City	125
Mittleman, Frederick S	Prairie Village	125
Mizell, Myron W	Springfield	082
Mobley, Gilbert L	Springfield	082
Moeller, F. Delbert	Lake St. Louis	189
Moeller, Randall J	St. Joseph	030
Moffe, Thomas C	Springfield	082
Mohrman, Raymond F	Bridgeton	190
Mohs, Frank R	St. Louis	190
Mohsen, Aly M	Springfield	082
Molberg, Peter J	Springfield	082
Molden, C. Scott	St Louis	190
Molden, Chas A	Bridgeton	190
Mollman, H. Dennis	Chesterfield	190
Monaco, Michael	Harrisonville	125
Monafo, William W	St. Louis	190
Monaghan, Greg G	Columbia	026
Mongan, James J	Kansas City	125
Monroe, C. Dean	Columbia	026
Monson, Bruce	Mission	215
Monteleone, Patricia L	St. Louis	190
Montello, Samuel A	Shawnee Mission	125
Monterubio, Fred R, Jr.	St. Louis	190
Montes, Arturo C	Florissant	190
Montgomery, Austin F	St. Louis	190
Montgomery, Michael A	Kansas City	125
Moolsintong, Pornchai	St. Louis	190
Mooney-Smith, Patricia	Kansas City	125
Moore, Candice A	Topeka	215

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Moore, David L	125	Kansas City
Moore, De Armond	082	Springfield
Moore, Harry G, Jr.	190	St. Louis
Moore, Jack D	125	Kansas City
Moore, John M	125	Kansas City
Moore, Michael R	206	West Plains
Moore, Michael T	214	Nevada
Moore, Richard E	042	Cape Girardeau
Moore, Thomas B	102	Joplin
Moore, Walter L	190	St. Charles
Moore, Exec. Sec., Patty	001	St. Joseph
Mora, Alvaro	190	Bridgeton
Moran, Christopher J	190	St. Louis
Moran, Thos M	190	St Louis
Morantz, Robert A	125	Kansas City
Moranville, Benedict A	030	St. Joseph
Morehead, Wm E	070	Malden
Morehouse, Paul D	074	Washington
Moreton, David W	215	Columbia
Morey, Kirk P	190	St. Louis
Morgan, David B	125	Kansas City
Morgan, Dix R	042	Cape Girardeau
Morgan, Harry C	190	Waynesville
Morgan, John L	082	Springfield
Morgan, Richard L	125	Kansas City
Morgan, Stephan S	190	St. Louis
Morgan, W. Tom , Jr.	026	Columbia
Morgan, Willy J C	190	E. St. Louis
Moriconi, William J	190	St. Louis
Moritz, Gerald	190	Bridgeton
Moritz, K. Lynne	190	St. Louis
Morley, Mary A	190	Chesterfield
*Morley, Ronald F	058	Jefferson City
Morris, Alan H	190	St Louis
Morris, Barbara A	125	Cohoes
Morris, J H	125	Independence
Morris, John J	026	Columbia
Morris, R. William	190	St. Louis
Morrison, Arlen E	190	Chesterfield
Morrison, R. Gideon	178	Sedalia
Morrison, Richard A	125	Shawnee Mission
Morrison, Robert R	125	Kansas City
Morrison, Stephen K	082	Springfield
Morrison, Thos A	166	Aurora
Morrison, Tom V	208	Branson
Morrow, N. Eugene	082	Springfield
Morse, John P	070	Kennett
Morton, David J	190	St. Louis
Morton, Paul C	082	Springfield
Morton, Wayne L	214	Osceola
Mosbacher, Hugh E	125	Lee's Summit
Mosby, Larry D	026	Columbia
Moseley, F. Thomas	082	Springfield
Moses, Robert A	190	St. Louis
Mosley, Julian C	190	St Louis
Moss, Paul	125	Overland Park
Mossie, Raymond D	050	Gladstone
Motchan, Dennis G	190	Bridgeton
Mothershead, John L	030	St. Joseph
Motier, Thomas H	190	St. Louis
Mou, Susan M	125	Kansas City
Mowrey, Wm O	190	St Louis
Moya, Carlos E	030	St. Joseph
Mrosak, Daniel R	118	Lexington
Muckerman, Richard C, II	190	St. Louis
Muckerman, Richard I.C.	190	St. Louis
Muegge, F. David	082	Springfield
Muehlebach, Gregory F	215	Kansas City
Muehlebach, Victoria	215	Kansas City
Muelleman, Peter J	125	Independence
Mueller, Adolph R	102	Joplin
Mueller, Clarence E	190	O'Fallon
Mueller, John J	190	St. Louis
Mueller, Jos A	190	St Louis
Mueller, Martin J	125	Kansas City
Mueller, Randall E	026	Columbia
Muhammud, Faquir	190	St. Louis
Muhm, Harvard Y	189	St. Charles
Mujica, Patricio H	030	St. Joseph
Mukharji, Jhulan	125	Kansas City
Mulder, George D	030	St. Joseph
Mullarky, Wilbur A	190	Oviedo
Mullen, Jack	138	Bonne Terre
Mullen, Mary E	014	Mexico
Mullican, Charles N	030	St. Joseph
Mullins, Bernard L	050	Kansas City
Mullins, John E	190	Chesterfield
Mundy, William L	125	Merriam
Munger, Michael L	125	Kansas City
Munro, John S	125	Kansas City
Muraywid, Ahmad H	014	Mexico
Murdock, Nathaniel	190	St. Louis
Murphy, Daniel J	190	Bridgeton
Murphy, J. Peter , Jr.	190	St. Louis
Murphy, James A	030	St. Joseph
Murphy, John P	125	Overland Park
Murphy, Michael C	190	St. Louis
Murphy, Timothy P	030	St. Joseph
Murphy, Wm A, Jr.	190	St Louis
Murray, Eric	058	Jefferson City
Murrell, H. Jerry	026	Columbia
Muscato, Joseph J	026	Columbia
Muscato, Mary S	026	Columbia
Musick, Steven E	215	Columbia
Mutchnick, Norman	125	Kansas City
Muzaffaruddin, Mohammed	189	St. Louis
Myears, Donald W	082	Springfield
Myers, Carl M	125	Platte City
Myers, Duane E	102	Joplin
Myers, Gary H	190	Chesterfield
Myers, Geo H	125	Kansas City
Myers, Ivan T	190	St. Louis
Myers, John S	125	Kansas City
Myron, Mark C	125	Kansas City

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Nachtigal, Michael P	082	Springfield
Nadershahi, Hooshang H	002	St. Louis
Nagy, Al L	034	Poplar Bluff
Nagy, Rickey E	125	Kansas City
Nakra, Bharat Raj	190	St. Louis
Nakra, Rashmi R	190	St. Louis
Nanson, Duane	026	Columbia
Narayan, Dilip L	190	Chesterfield
Narkiewicz, Lawrence S	190	St Louis
Naseer, Riaz A	190	St. Louis
Nash, Helen E	190	St. Louis
Nash, Homer E, Jr.	190	St. Louis
Nathan, Lester J	190	St. Louis
Naunheim, Keith S	190	St. Louis
Navato, Jose R	125	Independence
Neal, James G	082	Springfield
Near, David M	190	Florissant
Neblett, Lewis M	082	Rogersville
Neblock, Tammy	215	Kansas City
Neely, J. Gail	190	St. Louis
Neighbor, Ernest H	125	Kansas City
Neihart, Robert E	125	Kansas City
Nelson, Bentley A	125	Leawood
Nelson, David E	082	Springfield
Nelson, Donald C	082	Springfield
Nelson, J. Roger	190	St Louis
Nelson, Michael J	125	N. Kansas City
Nelson, Paul W	125	Kansas City
Nelson, Richard E	125	Kansas City
Nemec, Edward S	190	St. Louis
Nepute, James A	190	St. Louis
Nesselrode, John H	125	Independence
Neu, Leo T, Jr	082	Springfield
Neu, Leo T, III	082	Springfield
Neuman, Neal	190	St. Louis
Newbold, Steven E	125	Kansas City
Newman, Mary J	166	Cassville
Newman, Matthew	190	St. Louis
Newman, Ramon E	125	Kansas City
Newman, Robert L	125	Kansas City
Newman, William R	102	Joplin
Newman-Koehn, Mica K	198	Marshall
Newport, Gerald	190	Florissant

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Newport, Mark D	082	Springfield
Nguyen, Helen T	030	St. Joseph
Nicholas, Stephen P	190	St. Louis
Nicholis, G. Ronald	125	Kansas City
Nichols, Margaret E	102	Joplin
Nichols, W. Kirt	026	Columbia
Nickell, Margaret B	125	Kansas City
Nickell, Michael D	102	Joplin
Nicolai, Chas H	190	St. Louis
Niedermeyer, George J	190	St. Louis
Nielsen, Carl H	190	St. Louis
Nielson, Michael H	125	Independence
Nierling, Dean A	026	Columbia
Niesen, Anna R	190	St. Louis
Niesen, Frank J	190	St Louis
Niesen, Thomas E	190	Chesterfield
Nieuwenhuizen, Maarten	026	Columbia
Nigh, Chas A	190	St. Louis
Nigro, Thomas L	125	Kansas City
Nishi, Toshio	190	St. Louis
Nitzel, Scott A	215	Kansas City
Nix, J. Gustavo	066	Bolivar
Nixon, Edward E	078	Gallatin
Noback, Richardson K	125	Kansas City
Nolan, Chas J	190	Chesterfield
Nolph, Georgia J	026	Columbia
Nolph, Karl D	026	Columbia
Noltensmeyer, Milton H	125	Shawnee Mission
Nomura, Roy M	190	St Louis
Noor, Sidi Y	174	Ste. Geneieve
Nordlicht, Scott M	190	St. Louis
Norland, Chas C	190	St Louis
Nouhan, Joseph G, Jr.	190	St. Louis
Nourbakhsh, Mahmoud M	050	N. Kansas City
Nouri, Hassan	190	St Louis
Novack, Mark A	190	Chesterfield
Nowotny, Thomas J	190	St. Louis
Nuetzel, John A	190	St. Louis
Nussbaum, Larry	050	Liberty
Nwaobasi, Sam	190	Florissant
Nyazee, Muhammad A	190	Bridgeton

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O'Brien, Edward J, Jr.	190	St Louis
O'Brien, Robert M	190	St. Louis
O'Brien-Su, Eileen M	215	Merriam
O'Connell, Timothy	190	St. Louis
O'Connor, Edward F	120	Versailles
O'Connor, John J	074	St. Louis
O'Connor, Robert J	190	Florissant
O'Donnell, Francis E	190	St. Louis
O'Dowd, Mary K	002	Chesterfield
O'Farrell, Thos P	125	Kansas City
O'Hearne, John J	125	Kansas City
O'Keefe, James H, Jr.	125	Kansas City
O'Keefe, Timothy	102	Joplin
O'Kell, Richard T	125	Kansas City
O'Malley, James F	125	Leawood
O'Meara, Clifton B	178	Sedalia
O'Neal, Lawrence W	190	St. Louis
O'Neal, Patricia L	190	St. Louis
O'Neil, James H	125	Port Charlotte
O'Neil, Jerome H, Jr.	190	St. Louis
O'Reilly, D. Elliott	190	St. Louis
O'Rourke, James E	174	Ste. Genevieve
O'Sullivan, Danl F	190	St Louis
O'Toole, Lisa	215	Overland Park
O'Toole, Patrick M	125	Kansas City
Oakley, Margaret M	190	St Louis
Occeno, Victor G	166	Cassville
Ockner, Samuel A	190	St. Louis
Ohlms, David L	190	St Louis
Ojascastro, Alejandro C	190	St. Louis
Ojascastro, Lou	190	St. Louis
Ojile, Joseph M	190	St. Louis
Oleson, Gale B	125	Blue Springs
Olive, G. Chapman	082	Springfield
Olive, Geo C	166	Neosho
Olive, Paul M	082	Springfield
Oliver, G. Charles	002	St. Louis
Oliver, George A	138	Farmington
Olsen, Teresa A	082	Springfield
Olson, E. Rule	082	Springfield
Olson, James H	050	Liberty
Olson, Lloyd C	125	Kansas City
Olson, Richard O	189	St. Charles
Olson, Robert J	082	Springfield
Olson, Stephen A	215	Shawnee Mission
Omell, Gary H	190	St. Louis
Onder, Robert F	190	St. Louis
Ong, Eng L	190	St. Louis
Ong, Ofelia S	190	Town & Country
Onken, Henry D	190	St Louis
Oppenheimer, Henry E	190	St. Louis
Opper, Susan E	125	Kansas City
Oppermann, Karen J	125	Independence
Orgel, S. Michael	190	St Louis
Oro, John J	026	Columbia
Orr, Robert M	125	Kansas City
Orsay, Paul K	190	St. Louis
Ortbals, David W	190	Chesterfield
Orth, O. Gerald	026	Columbia
Ortiguero, Leopoldo M	190	St Louis
Ortmeyer, Leroy F	190	St. Louis
Osbourn, Richard A	038	Fulton
Osgood, Brian M	125	Independence
Ossman, Julian A	058	Jefferson City
Ost, Mark D	125	Kansas City
Ostapowicz, Frank	190	St. Louis
Ostapowicz, Tamara L	190	St. Louis
Ostergaard, Daniel J	125	Kansas City
Ostrow, Bridget F	042	Cape Girardeau
Ostrow, Louis B	042	Cape Girardeau
Othmer, Ekkehard	050	Kansas City
Ott, F. Thomas	190	St. Louis
Ott, Harold J	190	St Louis
Ott, William J	190	St. Louis
Otten, Joseph V	190	Bridgeton
Ottinger, Christopher M	125	Independence
Otto, William J	082	Springfield
Ouellette, David F	150	Hannibal
Ovens, Lisa	082	Springfield
Overend, Don S	082	Springfield
Overesch, Harry B	125	Kansas City
Owen, Robt F	190	St Louis
Owen-Kummer, Medge D	215	Kansas City
Owens, Robt H	125	Shawnee Mission
Owens, William D	190	St. Louis
Ozar, Milton B	125	Kansas City
Ozenberger, Larry A	054	Plattsburg
Ozmat, Orhan M	190	St Louis

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Pacheco, Jose M	082	Springfield
Packman, Paul	190	St Louis
Packman, Robt C	190	St. Louis
Padilla, Teresita C	190	Chesterfield
Padula, Richard T	125	Kansas City
Paez, Mauro A	190	St. Louis
Paff, David G	082	Springfield
Page, Sam L, Jr.	215	St. Louis
Paine, Robert	190	Chesterfield
Painter, Andrew E	202	Portageville
Painter, Lattie B	170	Portageville
Pal, Michelle L	125	Kansas City
Palazola, Joseph M	125	Kansas City
Palcheff, Chris L	082	Springfield
Palen, James E	042	Cape Girardeau
Palenske, Robt L	070	Hornersville
Paletta, Christian E	190	St. Louis
Paletta, Francis X, Sr.	190	St. Louis
Paletta, Frank	190	St. Louis
Paletta, Theodore L	190	St. Louis
Paletta, Victor L	190	Bridgeton
*Palmer, Allen S	190	Bridgeton
*Palmer, Bradley J	215	Mission
Palmer, Russell H	150	Palmyra
Palmer, Stephen M	190	St. Louis
Pancoast, Charles H	042	Cape Girardeau
Paone, Douglas B	125	Kansas City

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Pappalardo, Carlos St Louis	190
Papreck, K T Marshall	198
Paradelo, Jorge C Kansas City	125
Pardo, Leopoldo P St. Louis	190
Parelman, Allen G Kansas City	125
Parikh, Sharad P Florissant	190
Parikh, Smita S Florissant	190
Paris, Wm H Bridgeton	190
Park, Bert E Springfield	082
Park, T. S St. Louis	190
Park, Wm I, Jr Springfield	082
Parker, Arthur C Destin	034
Parker, Brent M Columbia	026
Parker, Craig A Kansas City	125
Parker, Kim E Kansas City	125
Parker, Lynn Edmond	215
Parker, Thos W St Louis	190
Parker, Wm St. Louis	190
Parkins, George K Kansas City	125
Parks, Charles St. Louis	190
Parks, Deborah L St. Louis	190
Parks, William C Columbia	026
Parra, Raul O St. Louis	190
Parres, Jeffrey A St. Louis	190
Parsons, Clyde W, III Springfield	082
Parsons, Richard P Marthasville	190
Partamian, Krikor O St. Joseph	030
Parulekar, Dilip G Fulton	038
Parwatikar, Sadashiv D St. Louis	190
Paskar, Larry D Chesterfield	190
Paskon, Seth Salem	135
Passanante, Bartholomew M St Louis	190
Patel, Ashokkumar B St. Louis	190
Patel, Bipin T St. Joseph	030
Patel, Indu B Barnhart	106
Patel, Natu B Bethany	078
Patel, Prakesh B St. Joseph	030
Patel, Raman J St. Joseph	030
Patrick, Roman L St. Louis	190
Patterson, Donald C Columbia	026
Patterson, Donald R Joplin	102
Patterson, Grover S Carthage	102
Patty, Carl F Poplar Bluff	034
*Patty, John R Poplar Bluff	034
Pauls, Scott W Kansas City	215
Paulson, Gordon S St. Joseph	030
Pavelonis, Joel D Kansas City	002
Pavlovich, Andrew S Independence	125
Pavlu, Robert R Waverly	118
Pawsat, John E Kansas City	125
Payne, David E Columbia	026
Payne, John W Fulton	026
Payne, Meredith C Chesterfield	190
Pearce, Eugene W. J. Kansas City	125
Pearman, Carl C St. Louis	190
Pearse, Carlton S Chesterfield	190
Pearse, Roy W Forsyth	214
Pearson, Thomas C Springfield	082
Pearson, William E St. Louis	190
Peck, William A St. Louis	190
Peden, Burnet W St. Louis	190
Peden, Virginia H St. Louis	190
Peeples, David M Ballwin	190
Peet, Brenda J Shawnee	215
Peete, Don C Prairie Village	125
Pehlman, Jos E Malden	070
Peick, Ann C Poplar Bluff	034
Peigh, Pamela S St. Louis	190
Pelican, George St. Louis	190
Pendell, Paul W Raymore	125
Pendergrass, Kelly B Kansas City	125
Penilla, Antonio R Bridgeton	190
Penkoske, Michaele M St. Charles	189
Pennell, Richard C St. Louis	190
Penney, Larry L Columbia	026
Penninger, William H Springfield	082
Pennington, D. Glenn St. Louis	190
Pennington, Michael S Springfield	166
Pennoyer, James St. Louis	190
Pentella, Karen J St. Louis	190
Peplinski, Gary R St. Louis	215
Pepose, Jay S St. Louis	002
Pepper, Edward G St Louis	190
Pereira, MaryBeth St. Louis	190
Perez, Adamor R St Louis	190
Perez, Blanca M St. Louis	190
Perez, Carlos A St Louis	190
Perez, Jeannie O Bridgeton	190
Perez, Robert J St. Louis	190
Perinetti, Enrique P St. Louis	190
Perkins, David E St. Louis	190
Perll, Maurice F, Jr. Kansas City	125
Perll, Michael F Kansas City	125
Perll, Rita D Kansas City	125
Perlmutter, John C St. Charles	189
Perlow, Joseph St. Louis	190
Perlstein, Laurence F Florissant	190
Perna, Vincent P St. Louis	189
Pernoud, Flavius G, III St. Louis	190
Pernoud, Flavius G, Jr. St. Louis	190
Pernoud, Joan M St. Louis	190
Pernoud, Michael F Chesterfield	190
Perry, Michael C Columbia	026
Perryman, Douglas R Kansas City	125
Perryman, J. Chris Kansas City	002
Perryman, Kathy M Kansas City	125
Perryman, William T Springfield	082
Peters, Walter R Columbia	026
Petersen, James H Chesterfield	002
Petersen, Larry D Springfield	082
Peterson, Carl M Kansas City	125
Peterson, Chas R Osage Beach	120
Peterson, Craig A Springfield	082
Peterson, Frederick D St Louis	190
Peterson, Jay T Kansas City	125
Peterson, John E Kansas City	125
Peterson, Stanley S Springfield	082
Peterson, Stephen E Kansas City	002
Peterson, Walter R Kansas City	125
Petit, Carl A Osage Beach	120
Petkovich, Frank O St. Louis	190
Petrie, Roy H St. Louis	190
Petros, John A University City	002
Petros, Teresa M University City	002
Petruska, Paul J St Louis	190
Pew, Becky A St. Louis	190
*Pewitt, Charles S Jackson	042
*Pfautsch, Mark L Cape Girardeau	042
Pfefer, Leland U Columbia	026
Pfeffer-Hurwitz, Judith Overland Park	125
Pfefferkorn, David A Sikeston	202
Phanijphand, Suwan Poplar Bluff	034
Phelan, Christie B Shawnee Mission	215
Phelan, David Kansas City	215
Philgreen, Donald E Kansas City	125
Phillips, Abraham M St. Louis	190
Phillips, Daniel St. Louis	190
Phillips, John J Florissant	190
Phillips, Ronald L Kirksville	148
Phillips, Stephen W Columbia	026
Phillips, Thomas P Kansas City	125
Phillips, Wm J Chesterfield	190
Philpott, Gordon W St Louis	190
Phipatanakul, Supote St Louis	190
Pickard, Clarence M Columbia	026
Pickard, Nicholas S Shawnee Mission	125
Pickens, Andrew T St. Louis	190
Picker, Selwyn St. Louis	190
Pickering, Lee I Independence	125
Picus, Joel St. Louis	002
Piebenga, Larry W Kansas City	125
Piehler, Jeffrey M Kansas City	125
Pignotti, Blase J St. Louis	190
Piker, K. Dewayne Springfield	082
Pimentel, Esperanza M St Louis	190
Pinckley, James N Springfield	082
Pineda, Hector O St Louis	190
Pineda, Juan J Columbia	215
Pingelton, William B Columbia	026
Pingleton, William W Shawnee Mission	050

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Pinkerton, Joe A, Jr.	Kansas City	125
Pinkham, Chris M	Kansas City	050
Piontek, James F	Liberty	050
Piontek, Jerome G	Chesterfield	190
Piper, August T	St. Louis	190
Piquette, Craig A	St. Louis	215
Pitiyanuvath, Tasanaporn	Kansas City	125
Pitney, Phillip W	Louisiana	186
Pitsinger, N. Bruce	Chesterfield	190
Pittman, David L	Columbia	026
Pittman, Gerald R	St. Louis	190
Pittman, Susan	St Louis	190
Pittmann, Thomas	St. Louis	190
Place, Kenneth C	Kansas City	125
Plax, Steven I	St Louis	190
Plous, Ronley H	Kansas City	125
Plowman, Edward M	Hannibal	150
Podrecca, Guido I	Springfield	082
Poger, Marshall E	St. Louis	190
Poggemeier, David A	St. Charles	189
Poggemeier, Wm H	St. Charles	189
Pogson, George W, III	Independence	125
Pohl, David L	St. Louis	190
Pojanasomboon, Pichat	Rolla	135
Politte, Lenard L	Columbia	026
Pomphrey, Martin M, Jr.	St. Louis	190
Pompushko, Rosalie	Kansas City	125
Pon, Marcelino	St. Louis	190
Pontillas, Job B	Perryville	174
Poole, Anthony G	Sikeston	202
Porter, Charles B	Kansas City	125
Porter, Michael J	Kansas City	125
Porter, Susan S	Kansas City	125
Porter, Walter N, Jr.	Lenexa	125
Portnoff, Lee S	St. Louis	190
Portnoy, Jay M	Kansas City	002
Porubsky, Gary L	N. Kansas City	050
Posey, Douglas H, Jr.	St. Joseph	030
Post, Stephen L	St Louis	190
Postma, George S, Jr.	Shawnee Mission	125
Potashnick, Robert	St. Louis	190
Pottenger, L. Kenneth	Joplin	102
Potter, Caryl A, Jr	St. Joseph	030
Potter, Reese H	St. Louis	190
Potts, Dan E	Chesterfield	190
Potts, Fred E, III	Springfield	082
Potts, Gregory A	Washington	074
Poulose, Abraham K	Kansas City	215
Powell, Alan E	Independence	125
Powell, Edwin M	Springfield	082
Powell, John A	St. Louis	190
Powell, Kenneth R	Springfield	082
Powell, Lisa G	Springfield	082
Powers, Catherine A	Leawood	125
Prater, Bill G	Springfield	082
Prater, Kimberley A	Springfield	082
Prater, Thomas G	Springfield	082
Prelutsky, David J	St. Louis	190
Prensky, Arthur L	St Louis	190
Presley, Jimmy C	Springfield	082
Preston, Bruce E	West Plains	206
Presutto-Nelson, Kathleen A	Springfield	082
Previti, Vincent	Springfield	082
Prewitt, David W	St. Louis	002
Prewitt, Maryann E	St. Louis	215
Prey, Marianne U	St. Louis	190
Prica, George , Jr	Columbia	026
Price, Hilton I	St. Louis	190
Price, Patrick K	Fairway	125
Price, Richard C	Harrisonville	214
Price, Richard B	Kansas City	125
Prickett, David C, Jr	Kearney	050
Pringle, Scot G	Cape Girardeau	042
Pro, John D	Kansas City	125
Probst, James R	St. Louis	190
Probst, Raymond E	St Louis	190
Proctor, Donald C	Sedalia	178
Prophete, Yves R	St. Louis	190
Proskey, Vincent J	Chesterfield	190
Prostic, Edward J	Kansas City	125
Prstojevich, Steven J	St. Louis	215
Pruett, Burchard S	Prescott	190
Pruett, Don S	St. Louis	190
Pruett, Paul L	Springfield	082
Pruitt, Robert M	Kansas City	215
Pryor, Harold J	Kansas City	125
Pryor, Ira Joe	Joplin	102
Puckett, Charles L	Columbia	026
Pugh, Richard G	Blue Springs	125
Purcell, Harry K	St. Louis	190
Purcell, Henry E	St. Louis	190
Purcell, John J, Jr.	St Louis	190
Purcell, Paul W	Renton	050
Purcell, Richard D	Springfield	082
Puro, Edward A	Florissant	190
Putnam, John L	Springfield	082
Pyeatte, Jacob P, Jr.	Cape Girardeau	042
*Pyron, Jimmy W	Joplin	102
Pyszczynski, Dennis R	Kansas City	125

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Qazi, Nasreen	St. Louis	190
Quer, Erich A	Shawnee Mission	125
Quesada, Eduardo W	Louisville	215
Quiason, Arturo G	Independence	125
Quiason, Emmeline P	Independence	125
Quick, Gary	Chesterfield	190
Quick, Richard T	St Louis	190
Quinn, Paul S	Strafford	082
Quinn, Rodney D	Springfield	082
Qureshi, Abdul R	St Louis	190

R

Raborar, Arteso C	Springfield	082
Rabun, John S	St. Louis	002
Rabushka, Sanford E	St. Louis	190
Rachlin, Maxwell	Ellington	190
Radel, Steven M	New Haven	074
Rader, Ada E	Kansas City	125
Rader, Edward S	St. Louis	190
Radford, Diane M	St. Louis	190
*Radinsky, Stephen	St. Louis	190
Radmanesh, Rebekah A	Kansas City	215
Ragland, John E	Crownpoint	058
Rahman, Moududur	Chesterfield	190
Railey, Michael T	St. Louis	190
*Rainbolt, Charles D	Farmington	138
Raju, Niranjana	Ste. Genevieve	174
Raksakulthai, Vinai	Fredericktown	138
Rall, Kenneth L	Independence	026
Ramey, Ehret O	Kansas City	125
Ramirez, Jose A	St. Louis	190
Ramirez, Raymundo E	Poplar Bluff	034
Ramirez, Ricardo M	Kansas City	034
Ramirez, Samuel G	St Louis	190
Ramirez-Inawat, Rebecca C	Chesterfield	190
Ramos, Americo G	Shawnee Mission	125
Ramos, Richardo R	St. Louis	215
Ramsey, J. Darryl	Cape Girardeau	042
*Ramsey, Jesse R	Cape Girardeau	042
Ramsey, Robt H	Florissant	190
Randall, Exec. Sec., Deonna	St. Charles	001
Randolph, Bernard C, Jr.	St. Louis	002
Randolph, Bernard C	St Louis	190
Randolph, Kerry A	Springfield	082
Rangineni, Rajagopal	St. Joseph	030
Rankin, Diane	St. Louis	190
*Rankin, Wendell D	Joplin	102
Rao, Aswath N	St. Louis	190
Rao, Carlo	Florissant	190
Rao, Sumati	St. Louis	190
Rapp, Earl L	Hannibal	150
Rappold, Henry O	Chesterfield	190
Rardin, Mary L	Kansas City	125
Rasmussen, Keith G	St. Louis	002
Ratcliff, Keith M	Washington	074
Ratkin, Gary A	St. Louis	190
Ratnam, Dasari V	Kansas City	125

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Rau, Michael E	Washington	074
Ravi, Latha	St. Louis	002
Rawlins, Fred E	Cape Girardeau	042
Rawson, Perry G	Washington	074
*Ray, Terry L	Columbia	026
Raybould, Michael W	Kansas City	125
Rayford, Walter	Kansas City	215
Raynor, Richard C	Marshall	198
Raza, Syed A	Belleville	190
Razzaq, A.	St. Louis	190
Rea, James L	Jefferson City	058
Reardon, Thomas M	Kansas City	050
Reardon, Thos F	St. Louis	190
Rector, Joe L	Shawnee Mission	125
Reddy, Abbiah N	Poplar Bluff	034
Reddy, Agara S	Columbia	026
Reddy, Anchala N	West Plains	206
Reddy, Nalini A	West Plains	206
Reddy, R. Ramachandra	Cape Girardeau	042
Reddy, Venoodhar K	Kansas City	215
Redfern, David L	Springfield	082
Redington, James C, Jr.	St. Louis	190
Redmon, Conchita M	Nixa	082
Rednam, Krishnarao V	Kirkwood	190
Reed, Glen H	Appleton City	214
Reed, Jonathan R	St. Louis	190
Reed, Timothy F	Moberly	046
Reeder, Chas C	Smithville	050
Reeder, Stephen M	Springfield	082
Reese, Jeffrey C	Chesterfield	190
Reese, Jon A	Springfield	082
Reese, Lester T	St. Louis	190
Reeves, R. Bradley	Joplin	102
Reeves, Col., Glen I	Chevy Chase	190
Regier, Carl M	Palm City	208
Reh, Edward P, Jr.	St. Louis	190
Reh, Thos E	St Louis	190
Reichert, Timothy J	St. Louis	190
Reinhard, Edward H	St. Louis	190
Reinhardt, J. Robert R	Kansas City	125
Reintjes, Stephen L	Kansas City	125
Reisler, David M	Chesterfield	190
Reiss, Jeanne E	Kansas City	125
Reister, Dorothy D	Shawnee Mission	125
Reister, Philip D	Kansas City	125
Reisz, Colleen C	Prarie Village	215
Rejent, Anthony J	St Louis	190
Remis, Robert E	St. Joseph	030
Rendleman, Geo F, Jr.	St. Louis	190
Rengachary, Dhanalakshmi	Kansas City	125
Rennard, Marvin	St. Louis	190
Renner, Gregory J	Columbia	026
Renner, John H	Kansas City	125
Repp, Theodore J, Jr.	St. Louis	190
Revare, Paul	Kansas City	050
Reyes, Efraim	Springfield	082
Reyes, Jose T	St. Louis	190
Reyes, Lirio M	Springfield	082
Reyes, Luis A	Arnold	190
Reynolds, James A	Chesterfield	190
Reynolds, Robert B, Sr.	Chesterfield	190
Reynolds, Susan K	St. Louis	190
Rezvani, Laghaieh	Sikeston	202
Rhee, Seoung E	St. Louis	190
Rhoades, Charles E	Kansas City	125
Rhoads, Jack V	Joplin	102
*Rhoads, Mark D	Joplin	102
Ribaudo, J. Michael	St. Louis	190
Ricci, Walter F	Shawnee Mission	125
Rice, Karen H	Jefferson City	058
Rice, Kathleen G	Springfield	082
Rich, Keith M	St. Louis	190
Rich, Margaret M	St. Louis	190
Richards, Dean D, III	Kansas City	125
Richards, Frank O	St Louis	190
Richardson, Geo A	Union	074
Richardson, Marion W	Kansas City	125
Richardson, Thomas F	St Louis	190
Richardson, Wm R	Union	074
Richert, Robert C	Kansas City	125
Ridenhour, C. E. Gene	Columbia	026
Ridenour, Brock D	St. Louis	190
Ridgeway, Wm G	St. Louis	190
Ridings, Harold D	Cape Girardeau	042
Ries, Douglas A	Chesterfield	190
Rigolosi, Ronald A	Kansas City	125
Rikli, Arthur E	Columbia	026
Riley, Chas T	Richmond	118
Riley, Joel Y	St. Louis	002
Riley, Louis T	Chesterfield	190
Riller, Lowell E	Kansas City	125
Rinck, Edward C	Nevada	214
Rinehart, Gregory C	St. Louis	190
Riner, Ronald N	St. Louis	190
Ring, Daniel S	Mission	215
Ringer, C. Nelson	Cape Girardeau	042
Riojas, Lisa A	Shawnee	215
Rippe, William F	St. Joseph	030
Rippey, John H	Kansas City	125
Rising, Dean R	Springfield	082
Ritter, C J	Cape Girardeau	042
Ritter, Carl F	Cape Girardeau	042
Ritter, Hubert A	St. Louis	190
Ritter, R. August	Overland	002
Ritter, Ray A, Jr	Cape Girardeau	042
Ritter, Raymond A, Sr.	Cape Girardeau	042
Ritter, William S	Kansas City	125
Rivera, Pepito C	Brookfield	078
Rizzo, Adolfo E	St. Charles	190
Robb, Christine A	Grandview	125
Robbins, Philip L	St. Louis	190
Robbins, Thomas D	Jefferson City	058
Roberts, Charles C	Kansas City	125
Roberts, Fred F	Kansas City	125
Roberts, Grosvenor G	Kansas City	125
Roberts, Harold K	Clayton	190
Roberts, Howard H	Joplin	102
Roberts, John P	St. Louis	190
Roberts, Perry T	Cape Girardeau	042
Roberts, Phyllis G	St. Joseph	030
Roberts, Shauna R	St. Joseph	030
Roberts, Theodore W	Sikeston	202
Robertson, Frank G	Cuba	190
Robertson, Wm D	Poplar Bluff	034
Robinett, Wade V	Kansas City	125
Robinson, Arthur W	Shawnee Mission	125
Robinson, Edith C	St Louis	190
Robinson, Gary L	Springfield	082
Robinson, Jay G	Kansas City	125
Robinson, Nicholas F	Kennett	070
Robinson, Ronald L	Cape Girardeau	042
Robinson, Van M	Marshall	198
Robinson, William A	Kansas City	125
Robinson, Wm J	Overland Park	125
Rockwell, Wayne L	Mission Hills	050
Rodefeld, Mark D	St. Louis	215
Rodes, Ned D	Mexico	014
Rodgers, Dorothy L	Columbia	026
Rodgers, George H	Leawood	125
Rodgers, Saml U	Kansas City	125
Rodrigo, Bernardo R	St. Louis	190
Rodriguez, Gregorio L	Charleston	202
Rodriguez, Raymond L	Belleville	190
Rodriguez, Ubaldo R	St Louis	190
Roehrs, David H	Sedalia	178
Roehrs, Marvin E	Marshall	198
Rogers, David B	Springfield	082
Rogers, H. Bryan	St. Louis	190
Rogers, James T	Springfield	082
Rogers, James D	Springfield	082
Rogers, John T	St. Joseph	030
Rogers, Joseph Drewry	Springfield	082
Rogers, Robt L	Kansas City	125
Roh, Joseph J	Kansas City	125
Roh, Lynn H	Kansas City	125
Rohrbaugh, James R	Chesterfield	190
Roller, James A	Columbia	026
Rollo, John L	St. Louis	190
Romaker, Ann M	Kansas City	125
Romkema, George E	St. Louis	190

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Roper, Charles L	St Louis	190
Rose, Barry A	Kansas City	125
Rose, John F	Chillicothe	078
Rosecan, Marvin	Belleville	190
Roselman, Michael J	Springfield	082
Rosen, Charles B	Kansas City	125
Rosen, Howard M	N. Kansas City	125
Rosen, Larry A	Independence	125
Rosen, William K	Springfield	082
Rosenbaum, Harry D	St. Louis	190
Rosenbaum, Herbert E	St. Louis	190
Rosenberg, David S	Florissant	190
Rosenbloom, Michael	St. Louis	190
Rosenblum, Barry N	St. Louis	190
Rosenquist, Chris R	Cape Girardeau	042
Rosenthal, Debra D	St. Louis	190
Rosenthal, Randall	St. Louis	190
Rosenthal, William N	Kansas City	125
Ross, Gilbert , Jr.	Columbia	026
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Strauss, Carl F	Kansas City	125
Strecker, William B	St. Louis	190
Stricker, Eamil A	Rolla	135
Stricker, William E	Rolla	135
Strickland, James C	St. Louis	190
Strimling, Robert B	St. Louis	215
Stringer, Kenton L	Aurora	166
Strobach, Kurt F	St. Louis	190
Stroble, Mark	St. Louis	190
*Stroemel, Mathias M	Bridgeton	002
Stromberg, Brent V	St. Louis	190
Stromberg, Eric D	Kansas City	125
Stronach, Linda L	St. Louis	190
Strong, Alexandra J	Kansas City	125
Stronsky, David	St. Louis	190
Stroud, Malcolm H	Dallas	190
Strunk, Robert C	St. Louis	002
Stryker, William I	Osprey	190

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Stuart, Byron M	Boonville	026
Stuart, Danl D	Brunswick	046
Stubbs, Thomas R	West Plains	206
Stuber, Robert R	St. Joseph	030
Stuckmeyer, James A	Blue Springs	125
Stuebner, Roland W	Kirkland	190
Stuerman, Lawrence G	Louisiana	186
Stufflebam, Brian W	St. Peters	189
Stufflebam, Robt E	Springfield	082
Stuppy, Mark S	Springfield	082
Sturtevant, Harwood N	Springfield	082
Su, Charles Y	Merriam	215
Su, Philo S	Jefferson City	058
Suarez, Alberto	Lee's Summit	125
Suarez-Solar, Pedro L	St. Charles	189
Subramanian, S.	Carthage	102
Suddarth, Sterling B	Kansas City	125
Sudekum, Joseph M	St Louis	190
Sueper, Robert H	St. Louis	190
Sugarbaker, Everett D	Jefferson City	058
Sullivan, Bradley H	Kansas City	125
Sullivan, Christine	Overland Park	125
Sullivan, Clement J	St. Louis	190
Sullivan, Dan T	Springfield	082
Sullivan, John A	Springfield	082
Sullivan, William W	St. Louis	190
Sultan, Tipu	Florissant	190
Sumer, Cengiz M	Bridgeton	190
Sumer, Emel A	Bridgeton	190
Summers, John B	St. Louis	190
Summers, Jos S	Jefferson City	058
Summers, Thomas F	Olney	190
Sunderji, Shiraz	St. Louis	190
Sundermann, Richard H	Chesterfield	190
Sundstrom, Frank D	Springfield	082
Sunshine, Herbert	St Louis	190
Suseela, Dasari	Kansas City	125
Susi, Jesse G	St. Louis	190
Sutherland, Charles J	St. Louis	190
*Suthoff, Jim	Joplin	102
Sutphen, Eric J	St. Louis	190
Sutter, Richard A	St. Louis	190
Sutton, Matthew B	Kansas City	215
Suva, Morfeo M	Springfield	082
Suvan, R	Poplar Bluff	034
Suwannasri, Rudee	St. Louis	190
Svancarek, William P	St. Louis	190
Swaim, Truett	Blue Springs	125
Swaney, Charles M	Columbia	026
Swango, John S	Springfield	082
Swank, Darrell	Joplin	102
Swanson, Eric	Kansas City	125
Swanson, Robert G	Ballwin	215
Swarens, Exec. Dir., C. C.	Jefferson City	001
Swaykus, Bernard T	Bridgeton	190
Sweeney, Michael J	Kansas City	125
Sweeney, Thos P	Springfield	082
Sweet, Robert A	Springfield	082
Sweiger, James H	Plattsburg	054
Swinfard, Ronald W	Columbia	026
Switzner, Diane L	Springfield	082
Sylvanovich, W. Richard	St. Louis	190
Sylvester, James	Columbia	215
Szabados, Ernest D	Independence	125
Szewczyk, Michael J	Columbia	026
Szoko, Edward	St. Louis	190
Szymanski, Stanley R	Macon	078

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Taege, Alan J	St. Joseph	030
Tailor, Chandrakant C	St. Louis	190
Takacs, Robert J	Kansas City	125
Talbert, Clifford R	Cape Girardeau	042
Talbott, Lawrence B	Kansas City	125
Talwar, Tara	Chesterfield	190
Tamblyn, Claire L	Tubac	125
Tanaka, Geo M	St Louis	190
Tang, Teodoro	Salem	135
Tanner, John P	Kansas City	125
Tanner, Robert H	Jefferson City	058
Tanphaichitr, Kongsak	St. Louis	190
Tansuwan, Chukiat	Ferguson	190
Taormina, Marc K	Independence	125
Tariq, Manzoor A	Chesterfield	215
Tate, Kara L	Kansas City	125
Tatkow, Robert W	St Louis	190
Taute, Hermann	St. Louis	190
Taylor, Eugene D	St. Louis	190
Taylor, John R.W.	Kansas City	125
Taylor, Leon A	Jefferson City	058
Taylor, Philip W	Cape Girardeau	042
Taylor, Steve J	Mexico	014
Taylor, William K	Springfield	082
Tayob, Anver A	St. Louis	190
*Tedrick, Phillip D	Cape Girardeau	042
Tekwani, Hiralal T	St Louis	190
Tellerman, Barbara J	Columbia	026
Templer, Jerry W	Columbia	026
Tendai, Mark M	Springfield	082
Tenorio, Arturo A	Stanberry	158
Tenorio, Gene	Springfield	082
Tenorio, Genoveva	Albany	158
Tepper, Arnold	St Louis	190
Ternberg, Jessie L	St. Louis	190
Terry, Boyd E	Columbia	026
Terry, James W	Cape Girardeau	042
Terry, James F	Springfield	082
Terschluse, David A	Bridgeton	190
Tess, Allen F	Florissant	190
Tess, Melvin J	St. Louis	190
Tessier, John E	St. Louis	190
Tetalman, Bruce I	St. Joseph	030
*Tewis, Huey D	Cape Girardeau	042
Thal, Sanford M	St. Louis	190
Thalblum, Harvey	Kansas City	125
Thale, Thomas R	Ballwin	190
Thawley, Stanley E	St. Louis	190
Thedinger, Bradley S	Kansas City	125
Theel, Otto W, Jr.	Shawnee Mission	125
Thibeault, Donald W	Kansas City	125
Thiel, J. Allen	St. Louis	190
Thiele, Belmont R	Las Vegas	190
Thiele, Otto K	St. Charles	189
Thierauf, Charles G	St. Louis	190
Thies, Jerome H	Osceola	214
Thoma, George E, Jr.	St. Louis	190
Thomas, Alexis G	Kansas City	125
Thomas, Christopher Y	Shawnee Mission	125
Thomas, Deborah G	Cape Girardeau	042
Thomas, F. Anthony	Kansas City	050
Thomas, Heather	Kansas City	215
Thomas, Horace E	Columbia	026
Thomas, J. Regan	St. Louis	190
Thomas, James J	Kansas City	125
Thomas, Leslie D	No Kansas City	050
Thomas, Maria D	Springfield	082
Thomas, Matthew A	St. Louis	190
*Thomas, Norvin E	Mexico	014
Thomas, Robert M	Columbia	026
*Thomas-Richards, Jose R	Kansas City	125
Thomasson, David D	Springfield	082
Thomasson, Jeffrey L	St. Louis	190
Thomasson, Mary W	St. Louis	190
Thompson, David E	Independence	125
Thompson, Eric	Columbia	026
Thompson, F Gregg	St. Joseph	030
Thompson, Frederick E	Liberty	050
Thompson, Frederick L	Nevada	214
Thompson, M. Bryant	Chesterfield	190
Thompson, Paul D	Cape Girardeau	042
Thompson, Robert W	St. Louis	190
Thompson, Robert F	Kansas City	125
Thompson, Scott W	Kansas City	125
Thompson, Susan	Plattsburg	054
Thompson, Exec V.P., James E	Springfield	001
Thornhill, Joseph M	St. Louis	190
Thornton, Fred H	Sikeston	202
Thornton, Michael K	Ste. Genevieve	174
Thorp, James A	Kansas City	125
Thorpe, William P	Cape Girardeau	042

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Throne, Ben J	Kansas City	125
Thurman, Jerome E	St. Louis	215
Thurmann, Manfred	St Louis	190
Tice, Wayne K	Lee's Summit	125
Tichenor, Robert W	Fenton	190
Tiefenbrunn, Sharon F	St. Louis	190
Tietjen, Fred O	Osage Beach	120
Till, Bennie N	Poplar Bluff	034
Tillema, David A	Kansas City	125
Tillinghast, Jeffrey P	St. Louis	190
Tillman, Mary A	St. Louis	190
Tilson-Mallett, Nancy R	Kansas City	125
Tilzer, Seth	Florissant	190
Tindall, Robert N	Spirit Lake	190
Tinsley, John C	Columbia	026
Tio, Liep T	West Plains	206
Tiojanco, Milagros E	Kansas City	125
Tippett, Jack C	St. Louis	190
Tobey, Albro C, Jr.	St. Louis	190
Tobin, Garry S	St. Louis	190
Tobin, Gregory A	Cape Girardeau	042
Tobin, Marla J	Higginsville	118
Tobin, Robert F	St. Joseph	030
Tobler, Jerry	St. Louis	190
Tobler, Randall W	St. Louis	190
Tombridge, Thomas L	Springfield	082
Tominack, Rebecca L	St. Louis	190
Tomlinson, David L	Kansas City	125
Tompson, Robt V	Moberly	046
Tong, Patrick Y	St. Louis	215
Torin, Bernice A	St Louis	190
Torontow, Raphael J	Nevada	214
Torrence, Ralph J	Bridgeton	190
Torres, Paul	Kansas City	050
Totty, William G	St. Louis	190
Toubes, Daniel B	Kansas City	125
Towle, Daniel J	Kansas City	125
Trachtenberg, Jeffrey D	St. Louis	215
Trammell, Lee W	Columbia	026
Traxel, Wm L	Poplar Bluff	034
Treadwell, Randall E	Alton	190
Trecha, Randal R	Columbia	026
Treiman, Robt C	St Louis	190
Trevor, Richard P	Kansas City	125
Trimble, Geo X	Kansas City	125
Trimmer, Jeanne M	St. Louis	190
Trinidad, Hermanito R	Chillicothe	078
Triplett, Daniel A	Liberty	050
Triska, Roland A	St. Louis	190
Troeh, Melvin R	Independence	125
Trombold, Walter S	Kansas City	125
Troop, Bryan R	St. Louis	190
Trotta, Philip C	St. Louis	190
Trotter, Francis O, Jr.	Carrollton	190
Trotter, W. Yates	Springfield	082
Trowbridge, Barnard C	Prairie Village	125
Trowbridge, Denise R	Olathe	002
Trowbridge, Ellsworth	Sun City	125
True, James D	N. Kansas City	050
Trueblood, Alva C	St Louis	190
Trueblood, Michael C	Cape Girardeau	042
Trugly, Edith S	St. Louis	190
Tsai, Cheng C	St. Louis	002
Tsang, John L	Honolulu	082
Tschudin, Garland	St. Louis	190
Tsifutis, Argyrios A	St. Louis	190
Tsolakoglou, Cleo	St. Louis	215
Tucker, Dolores R	Chesterfield	190
Tucker, Geo L	Chesterfield	190
Tucker, Leslie E	Washington	074
Tucker, Robert E	St. Louis	190
Tumanut, Benesto F	Gladstone	050
Tungsiripat, Soros	Kennett	070
Tuohy, Gerald F	Kansas City	125
Turano, Wm L	Raytown	125
Turfboer, Robert	Greenville	102
Turgeon, Ronald P	St. Louis	190
Turnbaugh, Thomas R	Jefferson City	046
Turner, Glenn O	Springfield	082
Turner, James D	Washington	074
Turner, Kirby L	Poplar Bluff	034
Turner, Marc A	Kansas City	125
Turner, Ronald M	Independence	125
Turner, Scott A	Osceola	214
*Turner, Timothy T	Barrington	002
Turner, William A	Nevada	214
Tutera, Dominic F	Kansas City	125
Tutera, Gino	Kansas City	125
Tuteur, Peter G	St. Louis	190
Tuttle, Jay F	Creve Coeur	138
Twedell, Donald L	Chestefield	190
Twyman, Richard A	Shawnee Mission	125
Tyler, Thomas D	Lexington	118
Tyndall, Robert J	Springfield	082
Tyree, Thomas A	St. Charles	190
Tze, Anthony A	St. Louis	215

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Uchiyama, Robert C	Chesterfield	190
Uhlemann, John H	St. Charles	189
Uhlemeyer, Henry A	St Louis	190
Uhrig, Jack R	Marshall	198
Uketui, Ozoemenam I	Kansas City	215
Umar, Ibrahim S	St. Peters	189
Underwood, Dick H	Leawood	125
Underwood, Johnson, III	Kansas City	050
Ungvari, Jos C	St. Louis	190

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Vacca, Jos B	St. Louis	190
Vafi, Houshang	St Louis	190
Vajaranant, Manit	Lexington	118
Valach, Frank J	St. Louis	190
*Vale, Janett A	Kansas City	125
Valera, Salvador S	Maryville	030
Vallurupalli, Vijayalakshmi	Bridgeton	190
Valtierra, Cesar A	Clayton	190
Valuck, Richard P, Jr.	Hannibal	150
Valverde-Mejia, Mary J	Sikeston	202
Van Amburg, Albert L, III	Chesterfield	190
Van Biber, James T	Blue Springs	125
Van Buskirk, Wm C	Kansas City	125
Van Dyke, Elmer H	Sedalia	178
Van Norman, Robert T	St. Louis	190
Van Osdol, Kelvin D	Springfield	082
Van Ryn, Jacques S	Bridgeton	190
Van Voorn, Catherine M	Columbia	026
Van Way, Charles W, III	Kansas City	125
Van Zanten, Niko A	Osceola	214
*Vandergraaf, Robert C	Cape Girardeau	042
Vandewalker, Mark L	Rolla	135
Vandivort, Paul M, Jr.	St. Louis	190
Vandover, John T	St. Louis	190
Vannier, Michael W	St. Louis	190
VanGoidsenhoven, Guy E	St Louis	190
VanVranken, Eugene E	Jefferson City	058
*Vardakis, Gregory M	Kansas City	215
Vargas, Theodoro C	Pacific	190
Varma, Devendra K	Poplar Bluff	034
Vatterott, Paul B, Jr.	Chesterfield	190
Vaughn, James W	Overland Park	125
Vaughters, Frank M	Kansas City	125
Veitch, John M	Joplin	102
Velasco, Ernesto T	St. Louis	190
Velloff, Tara M	Kansas City	215
Venable, H. Phillip	Ballwin	190
Venneman, Charles R	Kansas City	125
Vera, Enrique	Shawnee Mission	125
Verde, Julian N	St. Louis	190
Verdught, Ammon L	Lee's Summit	125
Vergara, Gerardo G	Kansas City	125
Vernava, Anthony M, III	St. Louis	190
Verona, Montgomery A	Springfield	082
Verzola, Eufemio G	Herculaneum	106
Vesely, Thomas M	St. Louis	002
Vest, James C	St. Louis	190
Vestal, Janie K	Springfield	082
Vestal, Juliette A	Springfield	082

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*Vialle, Gene M	125	Kansas City
Viamontes, Jorge A	190	St Louis
Vibulakaopun, Pairat	138	Bonne Terre
Vickar, Garry M	190	Florissant
Vidals, Victor G	125	Kansas City
Vierling, Stephen E	190	St. Louis
Viers, Wayne A	190	St Louis
Vietti, Teresa J	002	St. Louis
Vighi, James R	189	St. Charles
Vijungco, Jose G	190	St. Louis
Villahermosa, Juanito L	010	Savannah
Villamar, Elizabeth N	190	St. Louis
Villanueva, Angela A	125	Overland Park
Villarama, Antonio P	190	High Ridge
Vilmer, Charles E	050	N. Kansas City
Vilmer, Stephen E	050	N. Kansas City
Vinyard, Jack L	102	Joplin
Viril, Leonardo C	125	Kansas City
Visner, Sandra L	002	Springfield
Vitale, Anthony J	190	Chesterfield
Vitale, Nicholas S	190	St. Louis
Vitale, Stephen J	190	Ballwin
Vivian, Gary D	189	St. Peters
Viviano, Joseph G	190	Glendale
Vogel, Arthur P	125	Shawnee Mission
Vogel, Curt M	026	Columbia
*Vogelsang, Judith K	125	Kansas City
*Volarich, David T	190	St. Louis
Vollmar, Lewis C, Jr.	190	St Louis
Vollmer, Dennis G	190	St. Louis
Voth, Harold W	125	Shawnee Mission
Vournas, Christopher G	190	St. Louis
Vournas, George C	190	Bridgeton

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Wachter, Ronald M	082	Springfield
Wacker, Leo L	190	St Louis
Waddell, Kenneth E	082	Pleasant Hope
Waddell, Thomas H	125	Kansas City
Wade, Kim C	125	Kansas City
Wade, Larry A	082	Springfield
Wade, Terence P	190	St. Louis
Wadlow, Ernest E	030	St. Joseph
Wadsworth, Harry L	002	St. Louis
Waeckerle, Joseph F	125	Kansas City
Wagan, Primitiva C	190	St. Louis
Waggoner, Chas M	026	Columbia
Waggoner, Sharon E	030	St. Joseph
Wagman, Armin J	082	Springfield
Wagner, John R	190	St Louis
Wagner, Paul J	125	Greenwood
Wakeman, Newt , Jr	082	Springfield
Wald, Stanley M	190	St. Louis
Waldby, Gail E	078	Trenton
Walden, James M	125	Kansas City
Waldorf, James C	125	Kansas City
Walentik, Corinne	190	St Louis
Walentynowicz, James E	190	St. Louis
Walker, Ambrose T	206	Thayer
Walker, Andrew	150	Hannibal
*Walker, David Brooks	190	Bridgeton
Walker, Francis S	190	St Louis
Walker, Gary K	082	Springfield
Walker, Gregory E	125	Independence
Walker, Harvey , Jr.	190	St. Louis
Walker, Howard S	190	St. Louis
Walker, J Leslie	190	St. Louis
Walker, Kent D	215	Columbia
Walker, Melvin O, Jr.	082	Springfield
Walker, Orville C	125	Independence
Walker, Rebecca S	215	St. Louis
Walker, William M	082	Springfield
Wall, Harry C	125	Shawnee Mission
Wall, Joe A	206	Houston
Wall, Leonard A	125	Kansas City
Wall, Lester E	190	St. Louis
Wall, Norman R	082	Springfield
Wallace, Darryl L	125	Kansas City
Wallace, Elizabeth H	002	Kansas City
Walley, Lynn J	150	Hannibal
Walline, T. Andrew	215	Kansas City
Walls, Earlene H	125	Kansas City
Walls, Joseph T	026	Columbia
Walsh, Andrew L, III	215	St. Louis
Walsh, Barbara A	190	St. Louis
Walsh, James W	190	St Louis
Walsh, Martin J	189	St. Charles
Walsh, Richard J	030	St. Joseph
Walter, William L	190	St Louis
Walters, Henry W	190	St. Louis
Waltman, Stephen R	190	St. Louis
Walton, J. Douglas	202	Sikeston
Walton, Patrick J	125	Kansas City
Waltz, James R	050	Liberty
Walz, Bruce J	190	St. Louis
Wan, Shaw P	135	Rolla
Wankum, Robert P	058	Jefferson City
Wantuck, Donald K	082	Springfield
Warady, Bradley A	125	Kansas City
Ward, Joe W	118	Lexington
Ward, Mark	102	Neosho
Wareing, Thomas H	002	St. Louis
Waring, J. Michael	125	Kansas City
Warres, Herbert L	082	Springfield
Wasserman, Gary M	190	St. Louis
*Wasserman, Gary S	125	Kansas City
Wasserman, Mark S	190	St. Louis
Waterfield, Jim R	082	Springfield
Waterman, Franklin M	050	Overland Park
Waters, Hugh R	190	Chesterfield
Waters, Jeffrey A	125	Kansas City
Wathanacharoen, Suchint	125	Kansas City
Watkins, Geo L	138	Rancho Santa Fe
Watson, Richard A	030	St. Joseph
Watson, Tom F	082	Springfield
Watson, Trevor F	026	Columbia
Watts, Byron E	058	Jefferson City
Watts, Jane M	125	Orleans
Watts, Samuel M	166	Aurora
Wax, Martin B	190	St. Louis
Waxelman, Roger J	190	Ballwin
Waxman, Jane Z	125	Lenexa
Waxman, Joel E	082	Springfield
Waxman, Michael J	125	Kansas City
Wayne, Sherwyn J	190	St. Louis
*Weaver, Bruce E	026	Columbia
Weaver, Dana J	026	Columbia
Weaver, Mark E	082	Springfield
Weaver, Michael L	125	Kansas City
Webb, Harry E	125	Kansas City
Webb, James P	082	Springfield
*Webb, James J	102	Joplin
Webb, John M	050	Kansas City
Webb, Karen B	190	St. Louis
Webb, Paul B, Jr.	190	St. Louis
Webber, William B	190	St Louis
Weber, J. Russell	190	St. Louis
Weber, Thomas R	190	St. Louis
Weber-Bornstein, Nancy	042	Cape Girardeau
Weeks, Paul M	190	St Louis
Weide, Allan R	050	N. Kansas City
Weiford, Edward C	125	Shawnee Mission
Weigand, Robert T	030	St. Joseph
Weiler, Thomas J	190	St. Louis
Weinand, Ernest E	030	St. Joseph
Weinberger, Phillip C	118	Higginsville
Weinstein, Chas L	125	Kansas City
Weinstein, David L	190	St. Louis
Weinstein, Stephen H	026	Columbia
Weir, Don C	190	St. Louis
Weir, Robt K	125	Kansas City
Weir, Royal A	190	Ballwin
Weis, Ronald R	125	Kansas City
Weise, Marc W	190	St. Louis
Weiss, Alan N	190	St Louis
Weiss, Howard	190	St Louis
Weiss, James M	026	Columbia
Weiss, James J	058	Jefferson City
*Weiss, Randy B	102	Joplin
Weiss, Stuart	190	St Louis

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Weldon, Virginia V	St. Louis	190
Welke, Gordon A	Poplar Bluff	034
Wells, Donald E	Atlantic Beach	125
Wells, Samuel A, Jr.	St. Louis	190
Welsh, Jon A	Shawnee Mission	002
Welsh, Laurence C	St. Louis	190
Welsh, Thomas E, III	Mexico	014
Welter, Eugene S	Kansas City	125
Weltmer, John B, Jr.	St. Louis	190
Welton, Stephen T	Sikeston	202
Wempe, Geo R	Maryville	158
Wenneker, Alvin S	St Louis	190
Wenner, Herbert A	Merriam	125
Werner, Dean F	Kansas City	050
Werner, F. Scott	Kansas City	050
Werner, Franklin C	Liberty	050
Werner, Harold V	West Plains	206
Werner, William A	St. Louis	190
Werth, Joseph A	Jefferson City	058
*Wescott, Thomas P	Holden	110
West, Harold D	Independence	125
West, James C, Jr.	Kansas City	125
West, Joseph W	St. Louis	190
Westcott, Bruce R	Cape Girardeau	042
Westerfeld, Roy A	St. Charles	189
Westerman, Robt N	St Louis	190
Westfall, Scott G	Chesterfield	190
Westfall, Susan H	Chesterfield	190
Westgate, Steven J	Columbia	026
Westhoff, David D	Jefferson City	058
Weston, Kenneth G	Columbia	026
Westrich, David J	Cape Girardeau	042
Westrup, Ellsworth A	Eureka	190
Wetzel, Gus S	Clinton	086
Wexler, Stephen A	St. Louis	190
Weyerich, Noel F	St Louis	190
Weygandt, Paul L, Jr.	Columbia	026
Weyman, Philip J	Chesterfield	190
Whalen, Thomas R	St. Louis	215
Wheeler, Chas B	Kansas City	125
*Wheeler, Fredric R, II	Joplin	102
Wheeler, Paul D	Liberty	050
Wheeler, Robt L	Harrisonville	214
Whitacre, Marc M	Kansas City	125
Whitaker, James H	Kansas City	125
White, Barry B	Puxico	034
White, Bruce I	St. Louis	190
White, Chas H	Shawnee Mission	125
White, Eugene F	Rolla	135
White, Harry H	Columbia	026
White, Heidi K	Durham	215
White, Newton B	St. Louis	190
White, R. Ned	Springfield	082
White, Russell D	Aurora	166
White, Stoughton F	Shawnee Mission	125
White, Wm E	Kansas City	125
Whitehead, Clay C	St. Joseph	030
Whitener, Miles C	St. Louis	190
Whiteside, Leo A	Bridgeton	190
Whiting, Richard B	St. Louis	190
Whitlock, C. Courtney	Springfield	082
Whitman, Daniel S	Kansas City	125
Whitmore, J. Stewart	Washington	125
Whittaker, C. Keith	Kansas City	125
Whittaker, Thomas J	Kansas City	215
Whitten, J S	Cape Girardeau	042
Whitten, M. Foster	Carthage	102
Whittico, James M	St Louis	190
Wiant, James R	St. Louis	190
Wible, Jerry C	Springfield	082
Wice, Martin B	St. Louis	190
Wiegand, Herbert C	St. Louis	190
Wiele, Kimberly N	St. Louis	190
Wienke, Eugene C	St. Louis	190
Wiens, Robert D	St. Louis	190
Wientzen, Arthur S	Kansas City	125
Wiggins, Stanley D	Springfield	082
Wilbers, Raymond H	Mexico	014
Wilbois, Ronald P	St. Louis	190
Wilcox, Dennis M	Leawood	125
Wild, Alan P. K.	Chesterfield	190
Wilhelm, Warren F	Lake Ozark	125
Wilkins, Michael S	Kansas City	125
Wilkinson, David	St Louis	190
Wilkinson, Everett A	Prairie Village	125
Willcoxon, Robert L	Joplin	102
Williams, Carol F	St. Louis	190
Williams, Charlie B, Jr.	West Plains	206
Williams, Craig W	Cape Girardeau	042
Williams, Fred	Columbia	026
Williams, John M	Kansas City	050
Williams, John W, IV	Springfield	082
Williams, Joseph C	Shawnee Mission	125
Williams, Joseph	St. Louis	190
Williams, Kathleen M	Kansas City	125
Williams, Paul A	Kansas City	125
Williams, Paul A	St. Louis	002
Williams, R. Jerome , Sr.	St. Louis	190
Williams, Robert D	Kansas City	050
*Williams, Robert J	St. Joseph	030
Williams, Roland D	Shawnee Mission	125
Williams, Roy J, Jr.	St. Louis	190
Williams, Starks J	Kansas City	125
Williams, Wendell N	St. Louis	190
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Williamson, Geo L	Phoenix	050
Williamson, Harold A	Columbia	026
Williamson, Mark B, Jr.	Kansas City	125
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Wilson, David E	Smithville	050
Wilson, Geo P	Columbia	026
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*Wilson, James W	Springfield	082
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Wilson, Timothy A	Smithville	050
*Wilson, W. Timothy	Springfield	082
Wilt, David A	Kansas City	125
Wilucki, Melvin R	St Louis	190
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Winkelmeyer, William K	Columbia	026
Winn, Geo W	Boonville	026
Winnacker, John L	Columbia	026
Winsky, Arlen D	Springfield	082
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*Wright, James C Perryville	174
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Zoller, David D Blue Springs	125
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*Delaney, Adrain J, Jr.	Kansas City	125
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Kenney, John D, III	Kansas City	125
*Kesseler, Randall G	Springfield	082
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Laposky, Lynda L	Chesterfield	190
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Lawson, Noel W	Columbia	026
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*McLaughlin, Dan A	St. Joseph	030
McNitt, Jay D	Kansas City	125
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Morgan, Richard L	Kansas City	125
*Morley, Ronald F	Jefferson City	058
Morrison, Robert R	Kansas City	125
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Perryman, Kathy M	Kansas City	125
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*Shipman, Wade M	Springfield	082
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Waring, J. Michael	Kansas City	125
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*Weaver, Bruce E	Columbia	026
Weaver, Mark E	Springfield	082
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*Wright, Michael D	St. Joseph	030
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Foley, Jonathon K Cape Girardeau	042
Hannah, Hamner , III Prairie Village	125
Kase, James B, Jr. N. Kansas City	125
Kramer, Jeffrey B Prairie Village	125
Long, John W Columbia	026
Mangalat, Narayanan K Joplin	102
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Schuval, David	St. Louis	190
Vernava, Anthony M, III	St. Louis	190

D–DERMATOLOGY

Ailor, Susan K	Columbia	026
Albert, I. Renee	Overland	190
Anderson, Daphne W	Springfield	082
Anderson, Frank K	St. Charles	189
Anderson, Lynn A	Springfield	082
Anderson, Philip C	Columbia	026
Aronberg, Jerome M	St Louis	190
Ashby, Jennifer D	N. Kansas City	125
Bailey, Hugh R	Kansas City	002
Bauschard, Frederick D	St. Louis	190
Burkhart, Edward F	St. Louis	190
Chanasue, John A	Florissant	190
Creech, Fred T	Columbia	026
Dempsey, Kenneth J	Sikeston	202
DeSpain, John D	Columbia	026
Dilworth, Jacquelyn B	St. Louis	190
Dyer, Gary A	St. Joseph	030
Eisen, Arthur Z	St. Louis	190
Foote, Jerry E	Columbia	026
Forsman, Karen E	St. Louis	190
Gentry, Michael A	Springfield	082
Griffin, Darrell L	Farmington	138
Gunn, Victoria	Jefferson City	058
Gunnoe, Robert E	Kansas City	125
Hall, John C	Kansas City	125
Hilton, Paul E	Joplin	102
Hironimus, John E	St Louis	190
Hookerman, Bruce J	Bridgeton	190
Hruza, George J	St. Louis	190
Huewe, Douglas A	Springfield	082
Johnson, Dallas A	Overland Park	125
Key, James S	Springfield	082
Lane, Daniel K	St. Louis	190
Levenson, Ina	Poplar Bluff	034
Lorenc, Ernest	Springfield	082
Lynch, Thos W	Springfield	082
Major, Troy E	Springfield	082
Marrs, David B	St. Charles	189
McCadden, Michael E	St. Louis	190
Medler, P. Louis	St Louis	190
Melia, B J, Jr.	Kansas City	125
Miller, Charles W	St. Louis	190
Morrow, N. Eugene	Springfield	082
Muelleman, Peter J	Independence	125
Oleson, Gale B	Blue Springs	125
Palmer, Stephen M	St. Louis	190
Payne, David E	Columbia	026
Portnoff, Lee S	St. Louis	190
Powell, John A	St. Louis	190
Reese, Lester T	St. Louis	190
Roller, James A	Columbia	026
Schoentag, John S	St. Louis	190
Schoonmaker, Gene	Springfield	082
***Schwarze, Robert F**	Florissant	190
Scott, Jamie A	Springfield	082
Simmons, Jess S	Joplin	102
Stoecker, William V	Rolla	135
Swinfard, Ronald W	Columbia	026
Thomas, F. Anthony	Kansas City	050
Tiefenbrunn, Sharon F	St. Louis	190
Tucker, Dolores R	Chesterfield	190
Uhlemann, John H	St. Charles	189
Vitale, Stephen J	Ballwin	190
Vollmar, Lewis C, Jr.	St Louis	190
***Walker, David Brooks**	Bridgeton	190
Walsh, Richard J	St. Joseph	030
Werth, Joseph A	Jefferson City	058
Wolfe, Edward M	St Louis	190
Ziegler, Robert E	St. Louis	190
Zurowski, Susan M	Columbia	026

DR–DIAGNOSTIC RADIOLOGY

Amini, Jafar	Shawnee Mission	125
Anthony, James P	Kansas City	125
Applewhite, Thomas A	St. Louis	190
Balfe, Dennis M	St. Louis	190
Bartlett, John E	Springfield	082
Barton, Premsri T	St. Louis	190
Beal, Catherine E	St. Louis	190
Belshe, Sidney B	Jefferson City	058
Biermann, Robin S	Jefferson City	058
Bocchini, Thomas P	St. Louis	002
Brent, Lanny R, Jr	Springfield	082
Brown, Mike J	Cape Girardeau	042
Carlton, Lynn N	Springfield	082
Chow, Susanne M	Overland Park	125
Churchill, Robert J	Columbia	026
Claycomb, Gerald K	Chesterfield	190
Cloogman, Howard M	Overland Park	125
Cooper, Barry R	N. Kansas City	050
Crabtree, Jay B	Bolivar	066
Crepps, Louis F	St. Louis	190
Cronemeyer, Richard L	Leawood	125
Cubillo, Enrique	Chesterfield	190
Cupples, Tommy E	Cape Girardeau	042
Cusumano, Joseph V	St. Louis	190
Cyriac, George K	Mexico	014
Davis, Gene L	St Louis	190
Davis, W. Bob	Overland Park	125
Dell, Robert V	Hannibal	150
Dever, Robert L	Joplin	102
Devkota, Jagadishwar	Columbia	026
Dierberg, Dale F	Chesterfield	074
Edelman, Alan H	St. Louis	190
Ernst, Edwin C, III	St. Louis	190
Evens, Ronald G	St Louis	190
Fisher, James K	Kansas City	125
FitzSimmons, James G	Kansas City	125
Francis, Roger A	Osage Beach	120
Furlong, Lawrence D	Kansas City	125
Garrotto, Lewis J	Columbia	026
Garvin, Charles F	St. Louis	190
Gehm, Louis E	Butler	214
Geisse, Guillermo	St. Louis	190
Gennaoui, Jad M	St. Louis	190
Geurkink, John W	Joplin	102
Gibson, Merlyn D	Columbia	026
Glazer, Harvey S	St. Louis	190
Goetz, Joseph J	Overland Park	125
Goodhope, Karen F	St. Louis	190
Graviss, Edward R	St. Louis	190
Greditzer, Harry G	St. Louis	190
Gresick, Robert J, Jr.	St. Louis	190
Gusnard, Debra A	St. Louis	190
Hammerman, Albert M	St. Louis	190
Hammerman, Harley J	St. Louis	190
Hartman, Rodney C	Sedalia	178
Hazuka, David F	Shawnee Mission	125
Hinson, Gary W	Kansas City	125
Hoffman, Mark J	St. Louis	190
Idstrom, Mark E	Kansas City	125
Jacob, Kenneth M	Kansas City	125
Jones, Maynard C, Jr.	Lee's Summit	125
Jones, Paul S	Joplin	102
Jost, R. Gilbert	St. Louis	190
Junker, James A	St. Louis	106
Keller, Stephen M	St. Louis	190
Kelling, E. Collyer	Springfield	082
Koontz, Kenneth L	Kansas City	125
Lee, H. T.	Columbia	026
Levine, Richard S	St. Louis	190
Levitt, Robert G	St. Louis	190
Looney, Steven C	St. Joseph	030
Mayes, Ben R	St. Louis	190
McClennan, Bruce L	St. Louis	190
Merkle, John A	St. Louis	190
Middleton, Mary A	St. Louis	190
Mirowitz, Scott A	St. Louis	190

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Moore, Michael T	Nevada	214
Moran, Christopher J	St. Louis	190
Morgan, John L	Springfield	082
Murphy, Wm A, Jr.	St Louis	190
Nelson, David E	Springfield	082
O'Toole, Patrick M	Kansas City	125
Olson, Robert J	Springfield	082
Omell, Gary H	St. Louis	190
Phillips, Stephen W	Columbia	026
Pohl, David L	St. Louis	190
Pottenger, L. Kenneth	Joplin	102
Price, Hilton I	St. Louis	190
*Radinsky, Stephen	St. Louis	190
Rosenthal, Debra D	St. Louis	190
Sabahi, Houman	St. Joseph	030
Sadhu, Vijay K	Columbia	026
Sanders, Harold L	Columbia	026
Sauer, James M	Springfield	082
Scheible, Robert F	St Louis	190
Schwegler, Robert G	Shawnee Mission	125
Shaplin, Alfred D	Ballwin	106
Smid, Anne A	Springfield	082
Smith, Emily L	St Louis	190
Sobky, George H	Louisiana	190
Soha, Joseph J, Jr.	Columbia	026
Speckman, Jerry M	Bowling Green	125
Stephenson, Robert E	Overland Park	125
Stevens, Edward M	St. Joseph	030
Stewart, James G	St. Louis	190
Stoecker, Willeford J	Cape Girardeau	042
Sullivan, Dan T	Springfield	082
Sullivan, John A	Springfield	082
Swaney, Charles M	Columbia	026
Sweeney, Thos P	Springfield	082
Szoko, Edward	St. Louis	190
Thalblum, Harvey	Kansas City	125
Thomasson, Jeffrey L	St. Louis	190
Tobler, Jerry	St. Louis	190
Trotta, Philip C	St. Louis	190
Vannier, Michael W	St. Louis	190
Vesely, Thomas M	St. Louis	002
Waddell, Thomas H	Kansas City	125
Weis, Ronald R	Kansas City	125
Wiele, Kimberly N	St. Louis	190
Wilcox, Dennis M	Leawood	125
Wilson, J. Mark	Springfield	082
Wolski, James R	Springfield	082
Wood, David G	Overland Park	125
Yates, Darrel W	St Louis	190

EM–EMERGENCY MEDICINE

Bell, Malinda H	Shawnee Mission	125
Berry, Danny T	Cape Girardeau	042
Blackburn, Michael D	Columbia	026
Blaine, James R	Springfield	082
Bonney, Saml C	Washington	074
Carter, Gary L	N. Kansas City	125
Conner, Patrick T	Springfield	082
Cordover, Mitchell B	St. Louis	002
Criscione, James R, Jr.	St. Louis	190
DeCoursey, Kenneth A	Cape Girardeau	042
Dunlap, Michael D	St. Joseph	030
DuMontier, Alan J	Chesterfield	190
*Gerdes, John M	Chesterfield	190
Heim, Mary L	Kansas City	002
Hicks, Robb R, IV	Cape Girardeau	042
Hierholzer, Rebecca S	N. Kansas City	125
Holbrook, C. R. , III	Kansas City	125
Julien, Rene	St. Louis	190
Keesal, Dennis	St. Charles	189
Kensel, Robert S	Springfield	082
Klippel, Allen P	St. Louis	190
Kolda, Michael A	Cape Girardeau	042
Labayen, Ricardo A	Overland Park	125
*Landers, Gary A	N. Kansas City	050
Leese, Philip T	Lenexa	125
Lewis, Lawrence M	St. Louis	190
Lorei, John M	Parkville	002
Maranan, Diosdado L	Arnold	106
McIntosh, Douglas A	Cape Girardeau	042
McMurry, Ted A	Springfield	082
McVey, Pamela S	Kansas City	125
Mobley, Gilbert L	Springfield	082
Moranville, Benedict A	St. Joseph	030
Nelson, Michael J	N. Kansas City	125
Newport, Mark D	Springfield	082
Nierling, Dean A	Columbia	026
Pancoast, Charles H	Cape Girardeau	042
Patel, Raman J	St. Joseph	030
Poggemeier, David A	St. Charles	189
Prickett, David C, Jr	Kearney	050
*Pyron, Jimmy W	Joplin	102
Quick, Gary	Chesterfield	190
*Ramsey, Jesse R	Cape Girardeau	042
Robinson, Ronald L	Cape Girardeau	042
Robinson, William A	Kansas City	125
Rush, Marvin R	Ste. Genevieve	174
Russell, Steven L	Liberty	050
Scarborough, Betty F	Shawnee Mission	125
Scarborough, Mark R	Kansas City	125
Schneider, Douglas A	Austin	002
Skeins, Edward J, Jr.	Springfield	082
Steele, Mark T	Kansas City	002
Stoliar, Bruce	St. Louis	190
Sullivan, Christine	Overland Park	125
Svancarek, William P	St. Louis	190
Szewczyk, Michael J	Columbia	026
*Tedrick, Phillip D	Cape Girardeau	042
Waeckerle, Joseph F	Kansas City	125
Weaver, Michael L	Kansas City	125
Weber-Bornstein, Nancy	Cape Girardeau	042
Zink, Thomas K	Columbia	026

END–ENDOCRINOLOGY

Duda, Ralph J, Jr.	Springfield	082
Duick, Daniel S	Cape Girardeau	042
Henson, Bruce E	Kansas City	125
James, Ronald C	Columbia	026
Koppers, Lawrence E	Kansas City	125
Kryshak, Edward J	Springfield	082
Rosen, Howard M	N. Kansas City	125
Sneid, David S	Kansas City	125
Sweet, Robert A	Springfield	082

FP–FAMILY PRACTICE

Abu Dalu, Ziad	St. Louis	190
Allan, James E	Jefferson City	058
Allcorn, Donald K	Lincoln	178
Alonso, J. Mario , Jr.	St Louis	190
Anglo, Luis B	St Louis	190
Asaro, Phillip V	St. Louis	190
*Asher, Kennett D	Jackson	042
Askew, John H	Sikeston	202
Atkinson, Lance D	Springfield	082
Auner, J. David	Ironton	138
Ayres, Willa J	Kansas City	125
Baker, Carl N	St. Louis	190
Baker, Donald L	Union	074
Barbe, David O	Mountain Grove	206
Bareis, Robt J	Marshfield	210
Bass, Elliott L	Kansas City	125
Belden, Jeffery L	Columbia	026
Bennett, John E	Jefferson City	058
Berner, Carol T	Springfield	082
Bernhardt, Gary D	Overland Park	125
Binz, Donald E	St. Peters	189
Bird, Jonathon M	Farmington	138
Boatright, Kevin	Farmington	138
Bodenhausen, Gary E	Blue Springs	125
*Bohn, Sara A	California	002
Bollier, Rene P	Overland Park	125
Bowles, Richard P	Liberty	050
Boydston, Catherine O	Odessa	118
Boydston, Wyatt W	Odessa	118
Bradley, J. Douglas	St. Joseph	030
Bradshaw, Wm D	Kansas City	125
Brockhaus, Jayne R	Kansas City	002
Brookreson, Alton D	Poplar Bluff	034
Brown, Merlin D	St. Joseph	030
Bruno, Ellen L	Columbia	026

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FAMILY PRACTICE

Brunworth, David	Washington	074
Buffaloe, Robert N	Jefferson City	058
Buie, Steven E	Kansas City	125
Burcham, Tom R	Farmington	042
*Bynum, Robert L	Ashland	026
Byrum, Fritz A	Ballwin	190
Cady, Roger K	Springfield	082
Caldwell, Fred	Poplar Bluff	034
Carranza, Mauro J	St. Louis	190
Carter, James E, Jr.	Kansas City	125
Caster, Philip W	Lebanon	115
Catron, David O	Cape Girardeau	042
Chaffin, Jerald D	Branson	208
Chastain, Chas W	Flat River	138
Chavez, Salvador	St. Louis	190
Chen, Alan J	Dexter	202
Collison, R Michael	Springfield	082
Colter, Kim D	Washington	074
Colwill, Jack M	Columbia	026
Comfort, Geo D	Mexico	014
Conde, Gary A	Joplin	102
Cooper, Chas W, II	Jefferson City	058
Cooper, Thomas J	Fulton	038
Covert, Richard A	St. Louis	190
Crane, John L	Lee's Summit	125
Cravens, William P	Fulton	038
Crespo, Horacio T	Warrenton	074
Crespo, Remedios R	Warrenton	074
Crist, Charles L	Cape Girardeau	042
Crist, Roderic C	Cape Girardeau	042
Dabbs, Wilbur D	Neosho	166
Dang, Robert C	Pleasant Hill	214
Davis, Carl S	Lee's Summit	125
Davis, Ernest E	Fenton	190
Dean, Walter E	Maryville	158
Dempsey, Herbert A	Lee's Summit	125
*Dempsey, Herbert E	Lee's Summit	125
Devabhaktuni, Rama Devi	Ballwin	190
DeLine, Jim	Macon	046
Dierker, Harry D	Columbia	026
Dimayuga, Nestor G	Mansfield	206
Dixon, Druery J	West Plains	206
*Dohanich, John P	Jackson	042
Domke, Henry F	New Bloomfield	058
Donnell, Harold E	De Soto	106
Donnell, William S, Jr	Bolivar	066
Dorsch, Stephen E	Independence	125
Downey, Jon P	Cape Girardeau	042
Drabinowicz, Sallie E	Springfield	082
Dunshee, Robt E	Maryville	158
Durnell, Monaford D	Kansas City	125
DuMontier, Edward H	Farmington	138
Dyer, Curtis W	Warrensburg	110
Ekern, H. Peter	Mexico	014
Elcock, Devera M	Ballwin	190
*Eldenburg, Steven C	Sedalia	178
Elliott, Wendell H	Poplar Bluff	034
Engelken, Michael K	Mound City	158
Ewigman, Bernard G	Columbia	026
Fakhoury, Donald A	Kansas City	050
Farley, W. Joe	Nixa	082
Fisher, Mary Jo	Springfield	082
Fletcher, James L, Jr.	Cape Girardeau	042
Florence, Kerry E	Washington	074
Fowler, Marvin L	West Plains	206
Frazier, Robt L	Sikeston	202
Garrett, Elizabeth A	Columbia	026
Gentry, Jim	Springfield	082
Gilbirds, William M, II	Kansas City	050
Glover, David	Warrensburg	110
Godar, Sharon A	Chesterfield	190
Goddard, Jerry L	Cape Girardeau	042
Goff, John E	Joplin	102
Good, Michael W	Springfield	082
Graden, William R	Springfield	082
*Graves, Karladine E	Kansas City	050
Grechus, John J	Farmington	138
Green, Wm R	St Louis	190
Greenlund, Nelson C	Nevada	214
Griffith, S Kent	Cape Girardeau	042
Grisham, Thomas D	Washington	074
Groce, Geo D	Fulton	038
Hall, David W	Springfield	082
Hall, Ernest , Jr.	Hollister	208
Hall, Terry E	Bethany	078
Halverson, Larry W	Springfield	082
Hamid, Rashid S	Marshall	198
*Hancock, Thomas J	Jefferson City	058
Hardy, Stanton L	Desloge	138
Harr, Patrick B	Maryville	158
Harris, Louis B	Bolivar	066
Haudrich, Steven J	Camdenton	120
Hayes, Lawrence L	Kansas City	050
Hayes, Nancy J	Mountain Grove	206
Hecker, Jos E	Poplar Bluff	034
Henselmeier, Dale M	Bridgeton	190
Hernandez, J. Humberto	Gerald	074
Herrmann, Deborah A	Marshall	198
Heutel, Lee B	St Louis	190
*Hevel, Robert W	Palmyra	150
Hite, Dennis E	Lebanon	115
Hoffmann, Alan L	Kansas City	125
Hofmeister, Roger W	Columbia	026
Holzem, Craig S	Washington	074
*Honderick, Richard T	Springfield	082
Howell, David T	Florissant	002
Hrabik, Brent	Tarkio	158
Hubbard, Sally L	Springfield	082
Huffman, Thos L	Branson	208
Humphrey, James D	Mound City	158
Hunter, James K, Jr.	Fairfax	158
Huss, Randall D	Rolla	135
Icaza, Ramiro	Jackson	042
*Isaacs, Victor E	Scott City	042
Jackson, Max G	Kansas City	125
Jary, Mark L	Ozark	082
Jenkins, Edward R	Waynesville	135
Johnson, Joseph E	Kansas City	125
Johnson, Lent C	Hannibal	150
Johnson, Patrick E	Farmington	138
Jones, Keith D	Warrensburg	110
Jones, Stanley G, Jr.	Sikeston	202
Kairuz, Bartolome C	St. Louis	190
Kanne, Marty A	Kansas City	050
Kapp, Dave	Perryville	174
Kappesser, Netajean G	St. Louis	190
Kasten, Mark C	Cape Girardeau	042
Kenney, Douglas R	Clinton	086
Kessler, William D, Jr.	Joplin	102
Kiekhaefer, Theodore C	St. Joseph	030
Kimlinger, William R	Jefferson City	058
Kinder, Doyle O	Springfield	082
King, Mark D	St. Louis	190
Klein, Kendel L	Mount Vernon	166
Koon, Benny H	Bolivar	066
Kraemer, Edwin T	Kansas City	125
Kruse, Carl R	Palmyra	150
Laatsch, Robt H	Poplar Bluff	034
Laiben, Gregg R	Kansas City	125
Lauber, Joseph J	St Louis	190
Legler, Larry E	Independence	125
Leroux, Gene H	Doniphan	034
Lischwe, Daniel H	Bridgeton	190
Lofgreen, Craig S	Kansas City	125
Long, Timothy P	Marthasville	074
Lueckenhoff, Rebecca R	Jefferson City	058
Luerding, Jeffrey A	Kansas City	050
Lukavsky, James P	Branson	208
Lutkewitte, Jos F	Ste. Genevieve	174
Madden, Michael L	Kansas City	125
Markway, Gregory A	Independence	125
Marshall, William G	Glasgow	026
Martin, Mark W	Lee's Summit	125
Martin, Robert A	West Plains	206
Masters, Edwin J	Cape Girardeau	042
McCullough, Timothy L	Chesterfield	002
McFarland, Rodney J	Neosho	166
McKinney, William D, Jr.	Belleview	138
Mehaffy, Orville A	Joplin	102
Mehr, David R	Columbia	026

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Meier, Francis X	Jefferson City	058
Memken, John A	Hannibal	150
Menchetti, Donald E	Springfield	082
Meyer, Jerry L	Concordia	118
Miller, William D	St. Joseph	030
Mitchell, Thos J	St. Clair	074
Molberg, Peter J	Springfield	082
Molden, Chas A	Bridgeton	190
Montes, Arturo C	Florissant	190
Morgan, W. Tom , Jr.	Columbia	026
Morton, Wayne L	Osceola	214
Mueller, Randall E	Columbia	026
Munger, Michael L	Kansas City	125
Myers, Carl M	Platte City	125
Newbold, Steven E	Kansas City	125
Newman-Koehn, Mica K	Marshall	198
Nolph, Georgia J	Columbia	026
Noor, Sidi Y	Ste. Geneieve	174
O'Connor, John J	St. Louis	074
O'Connor, Robert J	Florissant	190
O'Keefe, Timothy	Joplin	102
O'Rourke, James E	Ste. Genevieve	174
Ojascastro, Alejandro C	St. Louis	190
Ortiguero, Leopoldo M	St Louis	190
Osbourn, Richard A	Fulton	038
Ostergaard, Daniel J	Kansas City	125
Ottinger, Christopher M	Independence	125
Ouellette, David F	Hannibal	150
Palen, James E	Cape Girardeau	042
Papreck, K T	Marshall	198
Paris, Wm H	Bridgeton	190
Parks, William C	Columbia	026
Patel, Natu B	Bethany	078
Patterson, Donald R	Joplin	102
Pennington, Michael S	Springfield	166
Perlow, Joseph	St. Louis	190
Philgreen, Donald E	Kansas City	125
Phillips, Ronald L	Kirksville	148
Piker, K. Dewayne	Springfield	082
Pimentel, Esperanza M	St Louis	190
Pinkham, Chris M	Kansas City	050
Pitney, Phillip W	Louisiana	186
Poggemeier, Wm H	St. Charles	189
Pon, Marcelino	St. Louis	190
Porter, Walter N, Jr.	Lenexa	125
Presley, Jimmy C	Springfield	082
Preston, Bruce E	West Plains	206
Prica, George , Jr	Columbia	026
Price, Richard C	Harrisonville	214
Radel, Steven M	New Haven	074
Railey, Michael T	St. Louis	190
*Rainbolt, Charles D	Farmington	138
Randolph, Bernard C	St Louis	190
Rardin, Mary L	Kansas City	125
Ratcliff, Keith M	Washington	074
Reeder, Chas C	Smithville	050
Renner, John H	Kansas City	125
Reyes, Efraim	Springfield	082
Reyes, Luis A	Arnold	190
Reynolds, Susan K	St. Louis	190
Rhee, Seoung E	St. Louis	190
Richardson, Geo A	Union	074
Riley, Chas T	Richmond	118
Robb, Christine A	Grandview	125
Robbins, Thomas D	Jefferson City	058
Roberts, Theodore W	Sikeston	202
Rogers, H. Bryan	St. Louis	190
Rosen, William K	Springfield	082
Rosenquist, Chris R	Cape Girardeau	042
Royce, Debra L	Sarcoxie	102
Rues, Lawrence A	Kansas City	125
Ryan, David	Trenton	078
Salanski, Stephen C	Lee's Summit	125
Sandberg, Chris B	St. Joseph	030
Schmitz, Ralph A	Monett	166
Schroff, Carle E	Springfield	082
Schutz, John P	Excelsior Spgs.	050
Scott, E. David	Jefferson City	058
Scott, Kenneth F	Clinton	086
Scully, Bruce D	Clinton	214
Seale, Stuart A	Springfield	082
Sells, Kenneth J	Kansas City	125
Shaw, James T	Hermann	074
Shaw, Robert D	Willow Springs	206
Shields, Lawrence S	Springfield	082
Shinn, Michael E	Kansas City	050
*Sill, William	St. Peters	189
Silvers, L. Michael	Kansas City	125
Sincox, Chas H	Washington	074
Sitzmann, Bryan L	Kansas City	050
Smith, Claude F	Willow Springs	206
Smith, Gilbert D	Poplar Bluff	034
Snider, Gregory T	St. Louis	190
Soper, Wm D	Liberty	125
Sparkman, Thomas C	Cape Girardeau	042
Spence, Paul A	Cape Girardeau	042
Spencer, Donald C	Fulton	026
Spurney, Joe E	Kansas City	125
Staten, Stephen F	St Louis	190
Steenbergen, Michael	Jefferson City	058
Steiner, Marvin P	Independence	125
Stelmach, Walter J	Kansas City	125
Stine, G. Wayne	Springfield	082
Stone, Kenneth D	Sikeston	202
Stringer, Kenton L	Aurora	166
Stuerman, Lawrence G	Louisiana	186
Suarez, Alberto	Lee's Summit	125
Tanner, Robert H	Jefferson City	058
Thies, Jerome H	Osceola	214
Thomas, Deborah G	Cape Girardeau	042
Thompson, Frederick L	Nevada	214
Thompson, Scott W	Kansas City	125
Thompson, Susan	Plattsburg	054
Till, Bennie N	Poplar Bluff	034
Tobin, Marla J	Higginsville	118
Treadwell, Randall E	Alton	190
Turner, James D	Washington	074
Turner, Kirby L	Poplar Bluff	034
Turner, Scott A	Osceola	214
*Turner, Timothy T	Barrington	002
Van Zanten, Niko A	Osceola	214
Vargas, Theodoro C	Pacific	190
Vestal, Janie K	Springfield	082
Wacker, Leo L	St Louis	190
Walker, Ambrose T	Thayer	206
Walton, J. Douglas	Sikeston	202
Ward, Mark	Neosho	102
Waterman, Franklin M	Overland Park	050
Watts, Jane M	Orleans	125
Watts, Samuel M	Aurora	166
Weiss, James J	Jefferson City	058
Welsh, Jon A	Shawnee Mission	002
*Wescott, Thomas P	Holden	110
Weston, Kenneth G	Columbia	026
Wheeler, Robt L	Harrisonville	214
White, Barry B	Puxico	034
White, Russell D	Aurora	166
Williams, Paul A	Kansas City	125
Williams, Paul A	St. Louis	002
Williamson, Blake J	Kansas City	125
Williamson, Harold A	Columbia	026
Wilson, David E	Smithville	050
Wilson, Timothy A	Smithville	050
*Wilson, W. Timothy	Springfield	082
Wirths, Kimberly M	Springfield	082
Wood, Thos O	Poplar Bluff	034
Workman, Geo M	Hermann	074
*Wright, James C	Perryville	174
Wulfers, Michael C	Cape Girardeau	042
Wurm, Michael J	Maryville	158
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*Yocum, Russell S	Platte City	125
Young, Robt B	Rolla	135
Zanol, John M	Columbia	026
Zweig, Steven C	Columbia	026

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Cortez, Edwin A	Kansas City	125

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DeLeeuw, Karel A Springfield	082
Jernstrom, Vance R Kansas City	125
Moore, David L Kansas City	125
Silverberg, Bruce St. Louis	002
Simo, Frank St. Louis	190
Tanner, John P Kansas City	125
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Allen, Mark J Kansas City	125
Barber, Gregory B Kansas City	125
Brand, Stanley N Kansas City	125
Brock, Arthur L Independence	125
Coleman, Matthew J Cape Girardeau	042
Coleman, Terrence W Independence	125
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Fedotin, Michael S Kansas City	125
Freeman, Michael R Cape Girardeau	042
Geisman, Richard A St. Peters	189
Gerhardt, Donald C Columbia	026
Ginsberg, B. William Kansas City	125
Gurian, Lawrence E Springfield	082
Helzberg, John H Kansas City	125
Honaas, Trygve O Cape Girardeau	042
Hover, Alexander R Springfield	082
Jacobs, Walter H Kansas City	125
Jennett, Richard B Jefferson City	058
Kipfer, Robt E Springfield	082
Kouo, Louis Cape Girardeau	042
Landers, Burnell Kansas City	125
Lee, Wilfred Cape Girardeau	042
Libel, Roy D Springfield	082
Lozoff, Richard D Kansas City	125
McCullough, Joseph E Kansas City	125
McPhee, Mark S Kansas City	125
Mentgen, Carl N Springfield	082
Mohrman, Raymond F Bridgeton	190
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*Schneider, Horace L Cape Girardeau	042
Shell, William C Sikeston	202
Taormina, Marc K Independence	125
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*Andrews, Lynthia B Kansas City	030
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*Bader, Larry W Columbia	026
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Baumann, Albert R Steelville	135
Bradley, Wm W Centralia	026
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Dudik, Randall G St. Joseph	030
Eldenburg, Donald O Sedalia	178
Folkner, Albert L Warrensburg	110
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*Gayle, David R Piedmont	034
*Gayle, Richard E Piedmont	034
Grable, James D Cape Girardeau	042
Gunn, Jack Versailles	120
Hamilton, Wm P Aurora	166
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Heath, Jimmy D East Prairie	202
Holley, Donald B Branson	208
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Howitt, William J Springfield	082
*Irinyi, Elmer T Gower	030
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*Lillig, James F Kansas City	050
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McGinty, Chas P	Cape Girardeau	042
McGinty, Frank H	Cape Girardeau	042
McGoff-Fahrner, Mari A	Webster Groves	002
Meiners, David J	St. Louis	190
Meiners, Paul N	St. Louis	190
Metzler, Michael H	Columbia	026
Meyer, Robert C	St. Louis	190
Meyer, Wayne W	Bridgeton	190
Meyers, Jerry R	St. Peters	189
Miedema, Brent W	Columbia	026
Mitchell, Franklin L	Columbia	026
Moffe, Thomas C	Springfield	082
Monafo, William W	St. Louis	190
Morehouse, Paul D	Washington	074
Mosley, Julian C	St Louis	190
Mrosak, Daniel R	Lexington	118
Muhm, Harvard Y	St. Charles	189
Mulder, George D	St. Joseph	030
Mutchnick, Norman	Kansas City	125
Nathan, Lester J	St. Louis	190
Near, David M	Florissant	190
Nelson, Paul W	Kansas City	125
Niesen, Frank J	St Louis	190
Niesen, Thomas E	Chesterfield	190
Nigh, Chas A	St. Louis	190
Nigro, Thomas L	Kansas City	125
Nourbakhsh, Mahmoud M	N. Kansas City	050
Nwaobasi, Sam	Florissant	190
O'Farrell, Thos P	Kansas City	125
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Occeno, Victor G	Cassville	166
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Parks, Charles	St. Louis	190
Parulekar, Dilip G	Fulton	038
Payne, Meredith C	Chesterfield	190
Peick, Ann C	Poplar Bluff	034
Pennell, Richard C	St. Louis	190
Perez, Adamor R	St Louis	190
Peters, Walter R	Columbia	026
Petit, Carl A	Osage Beach	120
Philpott, Gordon W	St Louis	190
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Reardon, Thomas M	Kansas City	050
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Reister, Philip D	Kansas City	125
Rendleman, Geo F, Jr.	St. Louis	190
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Rivera, Pepito C	Brookfield	078
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Rodriguez, Gregorio L	Charleston	202
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Rosen, Charles B	Kansas City	125
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Steiling, Sylvia A	St. Louis	190
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Tenorio, Arturo A	Stanberry	158
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Tompson, Robt V	Moberly	046
Torres, Paul	Kansas City	050
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Turner, William A	Nevada	214
Underwood, Johnson , III	Kansas City	050
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Wade, Terence P	St. Louis	190
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Webb, John M	Kansas City	050
Weinand, Ernest E	St. Joseph	030
Wells, Samuel A, Jr.	St. Louis	190
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Westerman, Robt N	St Louis	190
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Wilbers, Raymond H	Mexico	014
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Fuchs, Geo J	Columbia	026
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Jacob, Joe	Columbia	026
Kratz, Paul E	Cape Girardeau	042
Patterson, Donald C	Columbia	026
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Wolff, Gerald A	St. Louis	190
Woolery, William G	Sedalia	178
Wright, Jeffrey M	St. Louis	190
*Wright, Robert A	St. Louis	190
Wright, William P	St. Louis	190
Wuellner, David H	Sedalia	178
Yadav, Sanjay S	Kansas City	125
Yuhas, Michael E	Joplin	102
Zerr, Charles H	Independence	125
Zimmerman, Herbert B	St Louis	190
Zylka, J. Michael	St. Louis	190

MFM–MATERNAL & FETAL MEDICINE

Dix, Patricia M	Springfield	082
Hess, Leonard W	Columbia	026
Petrie, Roy H	St. Louis	190

N–NEUROLOGY

Abrams, Bernard M	Kansas City	125
Adelmann, Eugene	St. Louis	190
Ali, Syed S	Granite City	190
Allen, Arthur A, II	Shawnee Mission	125
Andrew, Christopher R	Joplin	102
Appelbaum, James S	Kansas City	125
Asher, Irving M	Columbia	026
Awadalla, Sylvia	St. Louis	190
Berg, Leonard	St. Louis	190
Bettinger, Irene E	Kansas City	125
Bhothinard, Bhisit	Poplar Bluff	034
Black, Joseph T	St Louis	190
Bonner, James S	St. Louis	190
Breeden, Richard L	Rolla	135
Briggs, Thomas B	Springfield	082
Brownsworth, Ronnie D	Springfield	082
Choi, Dennis W	St. Louis	190
Crowley, Wm J	Columbia	026
Davuluri, Sreenadha R	St. Joseph	030
Dean, Philip D	Washington	074
Desio, Marcus A	Joplin	102
Dexter, James D	Columbia	026
Dooley, Joseph M, Jr.	St. Louis	190
Downs, Mary K	Springfield	082
Eyerman, Edward L	St. Louis	190
Ferrendelli, James A	St. Louis	190
Ferry, Richard J	St. Louis	190
Geller, Bruce D	Kansas City	125
Hackett, Earl R	Springfield	082
Hanaway, Joseph	St Louis	190
Hatlelid, J. Michael	St. Louis	190
Hoffmann, Lee M	Shawnee Mission	125
Hogan, Patrick A	St Louis	190
Hooshmand, Ahmad	Jefferson City	058
Horenstein, Simon	St. Louis	190
Landau, Wm M	St. Louis	190
Lee, David Y S	Cape Girardeau	042
Legarda, Maria M	Kansas City	125
Lin, Chi-Hsi	Springfield	082
Luzecky, Michael H	Springfield	082
Makos, Mignon M	St. Joseph	030
Malkoff, Marc D	St. Louis	190
Margolis, Robert P	St. Louis	190
Matovich, Violet B	Kansas City	125
McLaren, David L	Columbia	026
*Mellies, Steven D	Cape Girardeau	042
Myers, Gary H	Chesterfield	190
Peeples, David M	Ballwin	190
Pentella, Karen J	St. Louis	190
Phillips, Daniel	St. Louis	190
Quinn, Rodney D	Springfield	082
Reisler, David M	Chesterfield	190
Reiss, Jeanne E	Kansas City	125
Robinson, Jay G	Kansas City	125
Rosenbaum, Herbert E	St. Louis	190
Rowe, Vernon D, III	Kansas City	125
Rymer, Marilyn M	Kansas City	125
Sanchez, Abelardo B	St. Louis	190
Sand, John J	Kansas City	125

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Satake, Robert L	125	Kansas City
Schreiber, Curtis P	082	Springfield
Schreiber, David J	190	Alton
Schultz, Earl R	190	St Louis
*Schwartzman, Michael J	125	Kansas City
Selhorst, John B	190	St. Louis
Shakil, Mohammad	042	Cape Girardeau
Sher, Allyn L	026	Columbia
*Sherrod, Glenn M	190	Bridgeton
Simowitz, Fredric M	189	St. Charles
Sohn, Richard	190	St Louis
*Stahly, Randall L	042	Cape Girardeau
Tyndall, Robert J	082	Springfield
Verona, Montgomery A	082	Springfield
Weinstein, Chas L	125	Kansas City
Weiss, Howard	190	St Louis
Weiss, Stuart	190	St Louis
White, Harry H	026	Columbia
Wong, George F, III	082	Springfield
Yanover, Robert A	190	St. Charles
Youmans, Ronald A	125	Kansas City
Yu, Carlos M, II	190	St. Louis
Yu, Mario K	125	Kansas City
Zimmerman, Devin D	190	Grover

NEP-NEPHROLOGY

Anderson, Sue K	125	Prairie Village
Benson, Larry E	050	N. Kansas City
Birenboim, Nancy	125	Kansas City
Braxton, Frank W	042	Cape Girardeau
Langley, Harriet S	125	Kansas City
Mir, A. Rauf	125	Kansas City
Nolph, Karl D	026	Columbia
Thomas, Alexis G	125	Kansas City
Winkelmeyer, William K	026	Columbia
*Young, Michael A	058	Jefferson City

NM-NUCLEAR MEDICINE

Allego, Melquiadito M	174	Perryville
Conlin, Chris	002	St. Louis
Donati, Robert M	190	St. Louis
Dukstein, Walter G, Jr.	125	Kansas City
Egbert, Robert N	082	Springfield
Gotti, Edward W	082	Springfield
Ho, Judith E	190	St. Louis
Holmes, Richard A	026	Columbia
Long, Stephen E	082	Springfield
Siegel, Barry A	190	St. Louis
*Volarich, David T	190	St. Louis

NPM-NEONATAL-PERINATAL MEDICINE

Braun, William J	125	Kansas City
Cole, F. Sessions	190	St. Louis
Kinney, Janet S	125	Kansas City
Slack, Melinda R	082	Springfield
Thibeault, Donald W	125	Kansas City

NR-NUCLEAR RADIOLOGY

Hacker, Douglas A	082	Springfield

NS-NEUROLOGICAL SURGERY

Albanna, Faisal J	190	St. Louis
Backer, Robert J	190	St. Louis
Bailey, Gregory J	190	St. Louis
Beatty, Robert M	125	Kansas City
Blatt, Geoffrey L	125	Kansas City
Bucholz, Richard D	190	St. Louis
Canlas, Mario P	082	Springfield
Chaudhari, A. Basit	042	Cape Girardeau
Cheung, K. Charles	042	Cape Girardeau
Chilton, Jonathan D	125	Kansas City
Clough, Chas A	125	Kansas City
Cole, Harry O	190	Chesterfield
Cox, Curtis S	058	Jefferson City
Coxe, Wm S	190	St Louis
Crabtree, H. Mark	082	Springfield
Crafts, David	190	St. Louis
Dacey, Ralph G, Jr.	190	St. Louis
Daus, Arthur S	102	Joplin
Ditmore, Q. Michael	026	Columbia
Dunn, Robert C, Jr.	190	St. Louis
Ferguson, John F	082	Springfield
Gall, Clifford M	125	Kansas City
Geise, August W	190	Chesterfield
Gold, Jonathan A	190	St. Louis
Goldring, Sidney	190	St. Louis
Greenberg, Jeffrey A	102	Joplin
Grubb, Robert L, Jr.	190	St. Louis
Hanson, E J	125	Kansas City
Hoffman, William F	190	St. Louis
Hornig, Gregory W	125	Kansas City
Jimenez, David F	026	Columbia
Kaufman, Andrew B	125	Kansas City
Kaufman, Bruce A	190	St. Louis
Kennedy, David G	190	St. Louis
Ketcherside, W. Joseph	050	Liberty
Kim, Yong Kie	042	Cape Girardeau
Krettek, John E	190	Chesterfield
Lattinville, Henry E	190	Bridgeton
MacGee, Edwin E	125	Kansas City
Majzoub, Hish S	102	Joplin
Marchosky, J. Alex	190	Chesterfield
Mendelsohn, George E	190	Chesterfield
Mollman, H. Dennis	190	Chesterfield
Morantz, Robert A	125	Kansas City
Mujica, Patricio H	030	St. Joseph
Nichols, Margaret E	102	Joplin
Oro, John J	026	Columbia
Orth, O. Gerald	026	Columbia
Pardo, Leopoldo P	190	St. Louis
Park, Bert E	082	Springfield
Park, T. S	190	St. Louis
Picker, Selwyn	190	St. Louis
Pittmann, Thomas	190	St. Louis
Reintjes, Stephen L	125	Kansas City
Rich, Keith M	190	St. Louis
*Routsong, Rodney T	190	St. Louis
Schoolman, Arnold	125	Kansas City
Scodary, Daniel J	190	Bridgeton
Sheehan, Paul J	190	Bridgeton
Silbergeld, Daniel L	190	St. Louis
Smith, Howard L	026	Columbia
Smith, Kenneth R, Jr.	190	St. Louis
Stohr, Paul E	190	St. Charles
Vollmer, Dennis G	190	St. Louis
Walker, Francis S	190	St Louis
Walker, Gregory E	125	Independence
Whitlock, C. Courtney	082	Springfield
Whittaker, C. Keith	125	Kansas City
Wilkinson, David	190	St Louis
Yoon, Kong-Woo	190	St. Louis
Young, Paul H	190	St. Louis

OBG-OBSTETRICS & GYNECOLOGY

Ahlering, Christopher L	190	St. Louis
Ahlering, George P	190	St. Louis
Ahlum, Sandra J	150	Hannibal
Ahmad, Nusrat J	190	Ballwin
Anstey, Geo C	190	St. Ann
Anstey, John T	190	St. Ann
Appelbaum, John K	002	St. Louis
Arias, Fernando	190	St Louis
Azan, Abraham N	178	Sedalia
Bagwe, Lata R	190	St. Louis
Baldwin, Richard M	082	Springfield
Bale, Robert D	190	St. Louis
Barloon, James H	125	Kansas City
Batts, Barbara A	125	Kansas City
Baumann, Daniel J	190	St. Louis
Beaty, Wm R	190	St. Ann
Becker, Robt L	190	St. Louis
Behrend, Ann E	125	Kansas City
Belew, Joe E	190	Chesterfield
Bell, Laird A	082	Springfield
Benitez, Jose A	190	St. Louis
Benson, Ronald G	082	Springfield
Benton, Mary Beth	026	Columbia
Bernabe, Florinio H	190	St. Louis

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Bever, Grant A	Harrisonville	214
Bickley, James E	Kansas City	125
Blaskiewicz, Robert J	St. Louis	190
Blythe, James G	St Louis	190
Boedeker, James P	St. Louis	190
Bohon, Barbara D	Kansas City	125
Bonebrake, Albert J	Springfield	082
Bonebrake, Mac D	Springfield	082
Bonfanti, Albert L	Bridgeton	190
Boone, Vicky L	Springfield	082
Bopp, J. Ronald	Joplin	102
Borello, Dan J	Joplin	102
Botney, Kathryn	Chesterfield	190
Boveri, Jos C	St Louis	190
Boyd, Craig W	St. Louis	190
Brennan, James M	St. Louis	190
Brennan, Robert A, Jr.	St. Louis	190
Brown, Cynthia L	Poplar Bluff	034
Brown, Robert J	St. Charles	189
Burks, Michael L	Columbia	026
Burstein, Robert	Richmond Hghts	190
Bury, Robert J	Overland Park	002
Calbert, Cythia C	Kansas City	125
Caruso, Alfred A	Kansas City	125
Caruso, Peter J	Leawood	125
Casey, Arthur L	St. Louis	190
Cassels, John W, Jr.	Columbia	026
Cernik, Christine M	St. Louis	190
Chesney, John W	Joplin	102
Chirino, Octavio R	St. Louis	190
Chod, Ronald J	Chesterfield	190
Clark, Larry K	Joplin	102
Cohen, Robert S	St. Louis	190
Comas, Manuel R	St. Louis	190
Cooper, Robt L, II	Warrensburg	110
Corder, Robt L	St. Joseph	030
Cornwell, Karen R	Kansas City	125
Coronado, Mario A	St Louis	190
Covarrubias, Jorge A	Collinsville	190
Coyne, Patrick M	Florissant	190
Crane, James P	St. Louis	190
Dagartzikas, A K	St. Louis	190
Dahm, Chas H, Jr.	St. Louis	190
Daly, James W	Columbia	026
Datta, Narendar K	St. Louis	190
Davidson, Raymond P	St. Louis	190
Del Pizzo, Ferdinand	St. Charles	189
Dement, Oman E	Joplin	102
Dent, George W	Farmington	138
DeRosa, Michael J	St. Louis	190
DeUngria, Pablo C	Bridgeton	190
Dieterich, Russell B	St. Charles	189
Dilts, Preston V, Jr.	Kansas City	125
Doan, Laura B	Raytown	125
Duello, Deborah K	Independence	125
Dugger, David E	St. Louis	190
Duncan, David T	St. Peters	189
Dunn, Melanie A	Kansas City	125
Durel, Justin H	St. Louis	190
Eachempati, Uma R	Arnold	190
Eaton, Paula	Kansas City	125
Ekunno, Josiah O	Florissant	190
Fast, Robert E	St. Joseph	030
Feldman, Mark R	St. Charles	189
Ferber, Alan J	Kansas City	125
Ferns, Francis E	Kansas City	125
Ferris, Robert E	Jefferson City	058
Fogle, Philip R	Springfield	082
Fortin, Jorge A	Rolla	135
Friesen, Randall G	St. Charles	189
Galakatos, Andrew E	Chesterfield	190
Gall, Ira C	St. Louis	190
Gardner, Joe A	Joplin	102
Garrison, David L	St. Joseph	030
Gay, John W	Columbia	026
German, Walter A	Springfield	082
Gimpelson, Richard J	Chesterfield	190
Goeking, C Keith	St. Joseph	030
Goldman, Gordon M	St. Louis	190
Gowen, Rose M	St. Louis	190
Grace, Steve	Springfield	082
Gray, Diana L	St. Louis	002
Grebe, T. Keith	Joplin	102
Green, Thomas F	Independence	125
*Greenspan, Peter B	Independence	125
Griffin, Wm T	Columbia	026
Gulick, C. Richard	St Louis	190
Gutknecht, Richard	Independence	125
Hahn, Yoram	Florissant	190
Halberstadt, Cathanie W	Kansas City	125
*Hamilton, William V	Lexington	118
Handler, Michael R	St. Louis	190
Hanley, Thomas P	St. Louis	190
Harms, Lawrence L	St. Louis	046
Hartman, Richard A	St. Louis	190
Hauser, Robert J	Jefferson City	058
Hayes, Kimberly W	Independence	125
Hazan, Joseph	Bridgeton	190
Heller, Randall L, Jr.	St. Louis	190
Herzog, Godofredo M	Florissant	190
Hickey, James L	St. Louis	190
Higgins, Philip C	St Louis	190
Hill, Randy C	Springfield	082
Ho, Grinny H	Arcadia	202
Hoja, John M	Poplar Bluff	034
Hoja, W Alex	Poplar Bluff	034
Houck, William E	St. Louis	190
Hubbell, George P	Osage Beach	120
Hulbert, Laura R	St. Louis	190
Hunleth, Frank E	St. Louis	190
Huse, William J, II	Kansas City	125
Huster, Robert M	Liberty	135
Ishida, Yasuo	St Louis	190
Jackson, Darwin C	Florissant	190
Jantsch, Deborah A	Kansas City	125
Jessup, Michael J	Cape Girardeau	042
Johnson, Jos C, Jr	Springfield	082
Johnson, Michael K	St. Louis	190
Johnson, Rebecca S	Kansas City	125
Jones, Jeffrey T	Joplin	102
Jones, Michael D	Mexico	014
Kaufmann, Herbert H	Kansas City	125
Keay, Myoung Soo	Chillicothe	078
Kelly, John B	Joplin	102
Keltner, Raymond O	Kansas City	125
Kessel, James W	St. Louis	190
Kim, Yang H	Washington	074
Kline, James	St. Joseph	030
Kobbermann, Kobby J	Springfield	082
Kobbermann, Thomas W	Liberty	050
Kovac, S. Robert	St Louis	190
Kraner, Justin F	St. Louis	190
Kratz, Donald P	Springfield	082
Kuebel, Richard J	St. Louis	190
Kumari, Vijaya	St. Louis	190
Lamping, J. Daniels	St. Louis	190
*Lentz, Rodney D	Jefferson City	058
Lim, Piemsak	Bridgeton	190
Lin, C H	Moberly	046
Lintecum, Frederick B	Kansas City	125
Liu, Ben C	Kansas City	125
Llorens, Alfred S	Columbia	026
Lockwood, Gary F	Kansas City	125
Madduri, Aruna D	Poplar Bluff	034
*Magill, William S	Springfield	082
Maitz, Carlos A	St. Ann	190
Maminta-Streiff, Maria G	St. Louis	190
Marshall, William H	Jefferson City	058
Marston, F. James	St. Joseph	030
Martin, Daniel J	St. Louis	190
Mathew, Ruby	Chesterfield	190
Matile, Gerald U	Kansas City	125
Maupin, Kathy C	Florissant	190
Maxson, Katherine A	Chesterfield	190
Maynard, Colleen M	Kansas City	125
McCorcle, Marcus D	Springfield	082
McDavid, Robert E	Columbia	026
McGuire, Thomas H	Shawnee Mission	125
McLaughlin, Richard D	Springfield	082
Medler, John F	St Louis	190

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OBSTETRICS & GYNECOLOGY-ONCOLOGY

Meiners, Theodore M	Chesterfield	190
Middleton, Jerry N	Chesterfield	190
Miller, Gerald L, Jr.	Kansas City	125
Mistry, Tehmton S	Chesterfield	190
Moeller, F. Delbert	Lake St. Louis	189
Monterubio, Fred R, Jr.	St. Louis	190
Mooney-Smith, Patricia	Kansas City	125
Mora, Alvaro	Bridgeton	190
Morley, Mary A	Chesterfield	190
Mou, Susan M	Kansas City	125
Muckerman, Richard C, II	St. Louis	190
Murdock, Nathaniel	St. Louis	190
Myers, Ivan T	St. Louis	190
Nagy, Rickey E	Kansas City	125
Newport, Gerald	Florissant	190
Nickell, Margaret B	Kansas City	125
Nielson, Michael H	Independence	125
Nouhan, Joseph G, Jr.	St. Louis	190
Nouri, Hassan	St Louis	190
Ojascastro, Lou	St. Louis	190
Ong, Ofelia S	Town & Country	190
Ostapowicz, Tamara L	St. Louis	190
Ott, Harold J	St Louis	190
Ott, William J	St. Louis	190
Otto, William J	Springfield	082
Padilla, Teresita C	Chesterfield	190
***Palmer, Allen S**	Bridgeton	190
Patty, Carl F	Poplar Bluff	034
***Patty, John R**	Poplar Bluff	034
Pearce, Eugene W. J.	Kansas City	125
Pearman, Carl C	St. Louis	190
Pearse, Carlton S	Chesterfield	190
Pearson, William E	St. Louis	190
Penney, Larry L	Columbia	026
Perryman, Douglas R	Kansas City	125
Pignotti, Blase J	St. Louis	190
Poole, Anthony G	Sikeston	202
Potts, Gregory A	Washington	074
Powell, Lisa G	Springfield	082
Pringle, Scot G	Cape Girardeau	042
Probst, James R	St. Louis	190
Probst, Raymond E	St Louis	190
Pyeatte, Jacob P, Jr.	Cape Girardeau	042
Raksakulthai, Vinai	Fredericktown	138
Rappold, Henry O	Chesterfield	190
Rawlins, Fred E	Cape Girardeau	042
Redfern, David L	Springfield	082
Reed, Jonathan R	St. Louis	190
Rengachary, Dhanalakshmi	Kansas City	125
Rennard, Marvin	St. Louis	190
Riley, Louis T	Chesterfield	190
Ritter, Hubert A	St. Louis	190
Robinson, Gary L	Springfield	082
Robinson, Van M	Marshall	198
Roter, Alexander M	St. Charles	189
Sachar, Jerome D	St. Louis	190
Saha, Sudha R	St. Louis	190
Salinas, Mario	St. Louis	190
Saneman, Paul P	Joplin	102
Sauvage, Jacques P	St Louis	190
Schaberg, Kevin B	Chesterfield	190
Schillie, Gene A	Kansas City	125
Schuetz, Evelyne G	St. Charles	189
Schwartz, Howard I	Kansas City	125
Seeck, Linda E	Washington	074
Shaner, Thomas P	St. Louis	190
Shelton, Becky R	Chesterfield	190
Shultz, Thomas M	Springfield	082
Siripipat, Pallop	Mexico	014
Smiley, William L	St. Louis	190
Smith, Brenda S	Kansas City	125
Snidle, William F	Crystal City	106
Snowden, Kent L	St. Louis	190
Sopuch, John A	St. Ann	190
Sowash, James J	Columbia	026
Spradlin, Larry D	Kansas City	125
Steiman, Barry	Creve Coeur	189
Stewart, Ronald M	Kansas City	125
Stockwood, Robt C	Sedalia	178
Strobach, Kurt F	St. Louis	190
Stuppy, Mark S	Springfield	082
Su, Philo S	Jefferson City	058
Sullivan, Bradley H	Kansas City	125
Sunderji, Shiraz	St. Louis	190
Taute, Hermann	St. Louis	190
Tendai, Mark M	Springfield	082
Thompson, M. Bryant	Chesterfield	190
Thornton, Michael K	Ste. Genevieve	174
Thorp, James A	Kansas City	125
Tobey, Albro C, Jr.	St. Louis	190
Tobler, Randall W	St. Louis	190
Trammell, Lee W	Columbia	026
Triplett, Daniel A	Liberty	050
Turano, Wm L	Raytown	125
Tutera, Gino	Kansas City	125
Vajaranant, Manit	Lexington	118
Van Dyke, Elmer H	Sedalia	178
Vestal, Juliette A	Springfield	082
Villamar, Elizabeth N	St. Louis	190
Vivian, Gary D	St. Peters	189
Walker, Gary K	Springfield	082
Walker, J Leslie	St. Louis	190
Walker, William M	Springfield	082
Wallace, Darryl L	Kansas City	125
Walley, Lynn J	Hannibal	150
Walsh, Barbara A	St. Louis	190
Wasserman, Gary M	St. Louis	190
Wasserman, Mark S	St. Louis	190
Weinstein, David L	St. Louis	190
Wheeler, Paul D	Liberty	050
White, Eugene F	Rolla	135
Whitten, J S	Cape Girardeau	042
Wilbois, Ronald P	St. Louis	190
Williams, Fred	Columbia	026
Williams, John W, IV	Springfield	082
Winer, Herbert J	Kansas City	125
Winkelmann, Susan E	Columbia	026
Wolff, Ray J	St. Louis	190
Wright, Andy J	Springfield	082
Wyrsch, Leo M	Springfield	082
Yahnke, David G	Farmington	138
Yang, John S	Ste. Genevieve	174
Yarwood, Robert L	Lake St. Louis	189
Yazdi, Tom M	Crestwood	190
Yeast, John D	Kansas City	125
Yoon, Jin S	Chillicothe	078
Zeller, Darrell E	Kansas City	125

OM-OCCUPATIONAL MEDICINE

Bailey, Marsha L	Arnold	190
Balster, Vernon H	St. Louis	190
Beeks, John W	Kansas City	125
***Cooper, Glen E**	Columbia	026
Evans, Charles	Jefferson City	058
Hedges, Richard C	Kansas City	050
Hughes, Robt G	St. Louis	190
Kopp, Shelby K	St. Louis	190
Meadows, C. Douglas	St Louis	190
Paff, David G	Springfield	082
Patel, Ashokkumar B	St. Louis	190
Welter, Eugene S	Kansas City	125

ON-ONCOLOGY

Adkins, Douglas R	St. Louis	002
Carolla, Robert L	Springfield	082
Chapman, Ramona Marie	Joplin	102
Cox, W. Welby	Springfield	082
Crosby, William H	Joplin	102
Cunningham, William F	Springfield	082
Fleming, Allan R	Kansas City	125
Hoos, Gary L	Springfield	082
LaFrancis, Irving E	Joplin	102
Matthews, Richard H	Rolla	135
Miller, Joseph P	Cape Girardeau	042
Myron, Mark C	Kansas City	125
Osgood, Brian M	Independence	125
Pendergrass, Kelly B	Kansas City	125
Perry, Michael C	Columbia	026
Skelley, Mark J	Joplin	102
***Stillie, G. Donald**	Kansas City	125

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Trowbridge, Denise R	Olathe	002
Van Amburg, Albert L, III	Chesterfield	190
Walls, Earlene H	Kansas City	125

OPH-OPHTHALMOLOGY

Amin, Navin J	St Louis	190
Arnold, Paul N	Springfield	082
Arribas, Neva P	St Louis	190
Assil, Kerry K	St. Louis	190
Avins, Laurence R	St. Louis	190
Bass, Walter R	Raytown	125
Bauman, Alan E	Kansas City	125
Becker, Bernard	St. Louis	190
Becker, Rolfe A	Kansas City	125
Becker, Stanley C	St Louis	190
Becker, William L	St. Louis	190
Benedett, Robert E	Springfield	082
Berdy, Gregg J	St. Louis	190
Berg, Edward F	Chesterfield	190
Bilchik, Ronald C	Chesterfield	190
Black, Thomas C, Jr.	Kansas City	125
Blinder, Kevin J	Columbia	026
Bloom, Jeffrey N	St. Louis	190
Bohigian, George M	St. Louis	190
Bonham, Roger D	Columbia	026
Boniuk, Isaac	St. Louis	190
Bourjolly, Wilson P	Florissant	190
Bowen, Stephen F, Jr.	St Louis	190
Brady, Harry R	St Louis	190
Brigham, David W	Ballwin	190
Bruce, Leo A	Sikeston	202
Burgess, Dean	St Louis	190
Byars, Steven R	Kansas City	125
Canaan, Samuel A, Jr.	St Louis	190
Case, Wm F	Kansas City	125
Catanzaro, Frank J, Jr.	St. Louis	190
Chavala, Sudarsan	Maryville	158
Cheek, Chas W	Columbia	026
Chipongian, Raul A	St. Louis	190
Chishti, M. Ishaq	St. Louis	190
Chu, Fred C	Chesterfield	190
Chung, Sophia M	St. Louis	190
Cibis, Gerhard W	Kansas City	125
Clever, Victor G	St. Charles	189
Cohen, Bruce H	St. Louis	190
Cokingtin, Cliff	Leawood	125
Cook, Jerry W	Kansas City	002
Couch, Jeffrey M	N. Kansas City	050
Cozean, Charles H	Cape Girardeau	042
Crapotta, Joseph A	St. Louis	002
Cundiff, H. Clay	Independence	125
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*Hunter, Harlen C	Chesterfield	190
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Glenn, Theodore J	042	Cape Girardeau
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Grossberg, George T	190	St. Louis
Guze, Samuel B	190	St. Louis
Hagen, Duane Q	190	St. Louis
Hall-Davis, Jacquelyn	190	St. Louis
Harrison, Richard L	190	St. Louis
Hartnett, Anna E	190	St. Louis
Hartnett, Thomas D	190	St Louis
Heimburger, Elizabeth M	026	Columbia
Hicks, Frederick G	190	St. Louis
Hicks, Robert S	190	St. Louis
Holemon, R. Eugene	190	St. Louis
Hornstra, Robijn K	125	Kansas City
Houghton, Howard L	125	Kansas City
Hudgens, Richard W	190	St. Louis
Hughes, Derek	026	Columbia
Hulstra, Johannes F	082	Springfield
Irvin, Wm M	190	St Louis
Jarvis, Stephen P	030	St. Joseph
Jones, Georgia A	190	St. Louis
Jones, Laird E	082	Springfield
Kamath, K.P.S.	042	Cape Girardeau
Katf, Nicola Y	050	N. Kansas City
Khan, Khawla B	190	St. Louis
Khojasteh, Saaid	190	St. Louis
Kitchen, Alice D	190	St. Louis
Kleinschmidt, Donn C	190	St. Louis
Kling, Ian A	074	Washington
Knowles, R. Raymond	190	Webster Groves
Kory, Steven M	190	Florissant
Kreisman, Jerold J	190	St. Louis
Krojanker, David N	190	St. Louis
Krojanker, Rolf J	190	St Louis
Kuhn, Lawrence F	190	St. Louis
Kulak, Gary	190	St Louis
Kulkarni, Satish R	189	Town & Country
Lamb, Wanda	190	St. Louis
Lamberti, Jos W	026	Columbia
Lensgraf, S. Jay	178	Sedalia
LeFevre, Philip J	082	Springfield
Lindgren, Carleton J	125	Independence
Lipschitz, Ervin	190	St Louis
Liss, Jay L	190	St Louis
Lucas, Thomas G	190	St. Louis
Lyskowski, John C	058	Jefferson City
Malmberg, Virgil L	190	Chesterfield
Mangunta, Vijaya K	202	New Madrid
Mauldin, Charles C	082	Springfield
McAfee, Gordon	082	Springfield
McKnelly, Wm V, Jr.	125	Kansas City
Meyer, Jay L	190	St. Louis
Meyers, Robert W	190	St. Louis
Milgram, Byron A	125	Kansas City
Miller, Jule P	190	St Louis
Mittleman, Frederick S	125	Prairie Village
Monroe, C. Dean	026	Columbia
Moran, Thos M	190	St Louis
Moritz, K. Lynne	190	St. Louis
Munro, John S	125	Kansas City
Nadershahi, Hooshang H	002	St. Louis
Nakra, Bharat Raj	190	St. Louis
Nakra, Rashmi R	190	St. Louis
Navato, Jose R	125	Independence
Neal, James G	082	Springfield
Nieuwenhuizen, Maarten	026	Columbia
Nowotny, Thomas J	190	St. Louis
O'Neal, Patricia L	190	St. Louis
Ohlms, David L	190	St Louis
Othmer, Ekkehard	050	Kansas City
Packman, Paul	190	St Louis
Parwatikar, Sadashiv D	190	St. Louis
Peterson, Stephen E	002	Kansas City
Pew, Becky A	190	St. Louis
Pickens, Andrew T	190	St. Louis
Pompushko, Rosalie	125	Kansas City
Post, Stephen L	190	St Louis
Pro, John D	125	Kansas City
Quiason, Arturo G	125	Independence
Quick, Richard T	190	St Louis
Rabun, John S	002	St. Louis
Rankin, Diane	190	St. Louis
Rasmussen, Keith G	002	St. Louis
Ratnam, Dasari V	125	Kansas City
Reddy, Agara S	026	Columbia
Reynolds, Robert B, Sr.	190	Chesterfield
Ricci, Walter F	125	Shawnee Mission
Richardson, Thomas F	190	St Louis
Rosenthal, Randall	190	St. Louis
Rutherford, James L	190	St. Louis
Ryall, Jo-Ellyn M	190	St. Louis
Sabet, Abdollah A	190	Ballwin
Saghir, Marcel T	190	St. Louis
Sata, Lindbergh S	190	St. Louis
Schmitz, John M	125	Kansas City
Seed, John C	190	St Louis
Segraves, Steven D	125	Kansas City
Sheffner, Paul W	190	St. Louis
Shen, Winston W	190	St. Louis
Siddiqui, Farzanna Q	190	Wood River
Simmons, Donald D	125	Kansas City
Simon, Nathan M	190	St. Louis
*Simpson, Floyd D	082	Springfield
Sitzman, Everette T	125	Kansas City
Sky, Adam J	190	St. Louis
Sletten, Ivan W	190	St Louis
Smith, Dermott A	190	St. Louis
Smith, James B	190	St. Louis
Snow, Emasue	082	Springfield
Soltys, Stephen M	026	Columbia
Sommer, Conrad S	190	St. Louis
Soorya, Narendir T	190	St. Louis
Soto, Albert A	190	St. Louis
Stewart, Harry A	125	Kansas City
Stillings, Wayne A	190	St. Louis
Suarez-Solar, Pedro L	189	St. Charles
Sumer, Cengiz M	190	Bridgeton
Sundermann, Richard H	190	Chesterfield
Thomas, Maria D	082	Springfield
Tilzer, Seth	190	Florissant
True, James D	050	N. Kansas City
Trugly, Edith S	190	St. Louis
Vafi, Houshang	190	St Louis
Valera, Salvador S	030	Maryville
Valtierra, Cesar A	190	Clayton
Vandivort, Paul M, Jr.	190	St. Louis
Vera, Enrique	125	Shawnee Mission
Viamontes, Jorge A	190	St Louis
Vickar, Garry M	190	Florissant
Wade, Larry A	082	Springfield
Whitehead, Clay C	030	St. Joseph
*Williams, Robert J	030	St. Joseph
Wilson, Roy E	082	Springfield
Wolff, Harold D	190	St. Louis
Wolfgram, Edwin D	190	St Louis
Yasin, Fazle M	190	St. Louis
Yates, John M	058	Jefferson City
Yoo, Chong-Sup	106	Festus

PD–PEDIATRICS

Accardo, Pasquale J	190	St. Louis
Aceto, Thomas , Jr.	190	St. Louis
Adams, W. Stuart	002	Florissant
Allen, Jerry H	074	Washington
Allphin, Barbara J	125	Kansas City
Altemeier, William A, III	026	Columbia
Alul, Mohammad Ali H	189	St. Charles
Amjad, Mohammad T	190	St. Louis
Andrews, Elizabeth J	082	Springfield
Barker, Edward T	190	St Louis

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PEDIATRICS

Barter, Bruce	Kansas City	125
Barton, Jean C	Excelsior	125
Bauer, Martin L	Prairie Village	125
Beal, Douglas W	Columbia	026
Beesley, Kari	Kansas City	002
Beidle, Raymond J	Bridgeton	190
Belen, Marietta	Festus	106
Benoist, Walter F	Chesterfield	190
Birmingham, Jean E	St. Louis	190
Blanton, Jos C	Sikeston	202
Blim, R. Don	Kansas City	125
Bloomberg, Gordon R	Chesterfield	190
Bordy, Marvin D	Kansas City	125
Bouhasin, John D	St Louis	190
Bowers, James E	St. Louis	190
Brehm, Martha A	Joplin	102
Britton, Loretta M	Kansas City	125
Bunge, Nancy J	Mexico	014
Burgdorf, Max H	Bridgeton	190
Burris, Garrett C	Chesterfield	190
Burry, Virgil F	Blue Springs	125
Bussmann, Yvonne L	Springfield	082
Cabal, Maria	E. St. Louis	190
Cantor, Harvey E	St. Louis	190
Carnahan, Chas E	Columbia	026
Casey, Eliot C	St Louis	190
Ceaser, Nancy H	Springfield	082
Charette, Richard P	Kansas City	125
Chauhan, Nazar C	Poplar Bluff	034
Chun, Chung S	Kansas City	125
Claseman, Wilma W	St. Louis	190
Clever, Henry W	St. Charles	189
Clothier, Robt W	Independence	125
Cokingtin, Diana L	Raytown	125
Cokingtin, Leovigildo C	Independence	125
Collins, Douglass D	Springfield	082
Cook, Katherine S	Rolla	135
Cygan, Ronald W	Kansas City	125
Dempsey, Maureen E	Columbia	026
DeCastro, Fernando J	Viburnum	138
DeSilva, Ananda	Hazelwood	190
Diehl, Elizabeth W	St. Louis	190
Diemer, Jean	Cape Girardeau	042
Dinkins, James A	Cape Girardeau	042
*Downs, Craig E	Springfield	082
Duggan, Eileen D	St. Louis	002
Duling, Gerald J	St. Charles	189
Edmonds, Robt W	Chesterfield	002
Edwards, Charles F	Moberly	046
Ewing, Lesley L	Kansas City	125
Farberman, Elliott	Florissant	190
Fernandez, Fernando	St. Joseph	030
Fitzmaurice, Laura S	Kansas City	125
Floyd, Marla J	Springfield	082
Flug, Eric J	St. Louis	190
Forgue, Donald R	Kansas City	125
Gassman, Ann A	Kansas City	125
Gauer, Robt J	Kansas City	050
Gellman, Elliot F	St Louis	190
Glines, Michael H	Arnold	190
Goerz, Ann A	Independence	125
Goldberg, Joseph P	Overland Park	125
Goldkamp, John D	St. Charles	189
Goldstein, David E	Columbia	026
Griesemer, Bernard A	Springfield	082
Groshong, Ted D	Columbia	026
Grunt, Jerome A	Kansas City	125
Guyer, Emily	Columbia	026
Hall, Robt T	Kansas City	125
Hamburg, Frederic L	Springfield	082
Hanks, Michael S	Springfield	082
Hansen, Thomas L	Independence	125
Harris, David J	Kansas City	125
Harris, Weldon L	Independence	125
Harrison, Thomas J, Jr.	St. Charles	189
Hartley, Robert D, II	St. Louis	190
Harwell, J. Larry	Clayton	190
Hellerstein, Stanley	Kansas City	125
Hellweg, Raymond W	Florissant	190
Henry, Roy A	Springfield	082
*Hey, Dennis J	Meridian	125
*Hoffman, James E	Cape Girardeau	042
Holland, Robt D	Springfield	082
Holleman, David N	Kansas City	125
Holmes, Nancy E	St. Louis	190
Horan, John J, Jr.	St. Louis	190
Howard, Campbell P	Kansas City	125
Hsu, Cecilia C	Shawnee Mission	125
Ip, Aidan W	St. Louis	190
Jackson, Mary Anne	Kansas City	125
James, Elizabeth J	Columbia	026
Jarka, Dale E	Kansas City	125
Jones, Patricia E	Kansas City	125
Jones, Robert R	Nevada	214
Kahn, Joseph A	St. Charles	189
Kanarek, Joseph	Kansas City	125
Keating, James P	St Louis	190
Keefe, David M	St. Charles	189
Kemp, Michele E	Chesterfield	190
Khan, Abdul G	Arnold	190
Khurana, Satish K	Lenexa	125
Kilbride, Howard W	Kansas City	125
Knapp, Jane F	Kansas City	125
Knock, Henry L	St. Louis	190
Kreusser, Katherine L	St. Louis	190
Krishna, Padma	Kansas City	125
Kronemer, Norton S	St. Louis	190
L'Ecuyer, Jerome L	St Louis	190
Lass, Nancy A	St. Louis	190
Latimer, Walter N	Gladstone	050
Levie, Benton B	Sikeston	202
Lieb, Francis X	Richmond	190
Limpiphiphatn, Ester P	Perryville	174
Livingston, Don G	Ballwin	190
Lyss, Stanley B	St Louis	190
Mann, James K	Hannibal	150
Matthews, Thomas D	Washington	074
McIntosh, Michele C	Independence	125
McKinney, Daniel C	Springfield	082
McNeal, Douglas M	Springfield	082
Mestres, Hugh M	St Louis	190
Meyer, John W	Springfield	082
Miller, Suzanne L	Grover	190
Mitra, Nirmal K	Kansas City	125
Monteleone, Patricia L	St. Louis	190
Morris, Barbara A	Cohoes	125
Motier, Thomas H	St. Louis	190
Muraywid, Ahmad H	Mexico	014
Murphy, Timothy P	St. Joseph	030
Naseer, Riaz A	St. Louis	190
Nash, Homer E, Jr.	St. Louis	190
Newman, Ramon E	Kansas City	125
Newman, William R	Joplin	102
Nicholis, G. Ronald	Kansas City	125
Nussbaum, Larry	Liberty	050
O'Neil, Jerome H, Jr.	St. Louis	190
Olson, Lloyd C	Kansas City	125
Oppermann, Karen J	Independence	125
Overend, Don S	Springfield	082
Palcheff, Chris L	Springfield	082
Peterson, Frederick D	St Louis	190
Petros, Teresa M	University City	002
Phillips, Abraham M	St. Louis	190
Pitiyanuvath, Tasanaporn	Kansas City	125
Pittman, Susan	St Louis	190
Plax, Steven I	St Louis	190
Powell, Alan E	Independence	125
Reed, Timothy F	Moberly	046
Reister, Dorothy D	Shawnee Mission	125
Rejent, Anthony J	St Louis	190
Reyes, Lirio M	Springfield	082
Rice, Kathleen G	Springfield	082
Rising, Dean R	Springfield	082
Roberts, Charles C	Kansas City	125
Roberts, Phyllis G	St. Joseph	030
Ross, Ryia	St. Louis	190
Ross, Wm J	Bridgeton	190
Ryser, Carol A	Kansas City	125
Sakmar, Douglas A	St. Louis	190
Sammon, T James	Springfield	082

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Sato, Geo	Chesterfield	190
Sato, Richard W	Chesterfield	190
Schlansky, Howard J	St. Charles	189
Schmidt, Martin P	St. Louis	190
Seshumurty, Vimala	Overland Park	125
Shapiro, A. James	Springfield	082
Sharma, Vidya	Kansas City	125
Sharp, Austin R	Ballwin	190
Sheehan, Michael B	Kansas City	125
Sherman, W. Gary	Chesterfield	190
Simon, David L	St. Louis	190
Simons, Paul S	St. Louis	190
Smith, Elbert E	Kansas City	125
Smith, Katherine W	Kansas City	125
Snyder, Christopher H, Jr	Springfield	082
Solanki, Nareshkumar J	Wentzville	190
Soucie, Carol J	Concord	002
Spewak, Robert D	St. Louis	190
Sponenberg, Don D	Springfield	082
Stiaszny, Louis K	Kansas City	125
Stiffelman, Anita	St. Louis	190
Sultan, Tipu	Florissant	190
Suseela, Dasari	Kansas City	125
Suvan, R	Poplar Bluff	034
Tenorio, Genoveva	Albany	158
Thompson, F Gregg	St. Joseph	030
Tillman, Mary A	St. Louis	190
Trimmer, Jeanne M	St. Louis	190
Triska, Roland A	St. Louis	190
Tschudin, Garland	St. Louis	190
Tsifutis, Argyrios A	St. Louis	190
Tungsiripat, Soros	Kennett	070
Umar, Ibrahim S	St. Peters	189
Vaughters, Frank M	Kansas City	125
Vietti, Teresa J	St. Louis	002
Walentik, Corinne	St Louis	190
Walker, Orville C	Independence	125
Warady, Bradley A	Kansas City	125
*Wasserman, Gary S	Kansas City	125
Waters, Jeffrey A	Kansas City	125
Waxelman, Roger J	Ballwin	190
Weldon, Virginia V	St. Louis	190
Westerfeld, Roy A	St. Charles	189
*Wheeler, Fredric R, II	Joplin	102
Williams, Kathleen M	Kansas City	125
Williamson, Mark B, Jr.	Kansas City	125
*Wilson, James W	Springfield	082
Wimmer, Warren J	Florissant	190
Woods, Gerald M	Kansas City	125
Wool, Gerald	St Louis	190
Zahn, Robt L	Springfield	082

PDA–PEDIATRIC ALLERGY

Cannon, Richard E	St. Charles	189
Corry, James M	St. Louis	190
Leslie, Stephen A	Gladstone	050
Loren, Michael L	Independence	125
Perez, Jeannie O	Bridgeton	190
Portnoy, Jay M	Kansas City	002
Schulman, Jeffrey I	St. Louis	190
Siegel, Charles	Gladstone	050

PDC–PEDIATRIC CARDIOLOGY

Canent, Ramon V	Kansas City	125
Gowdamarajan, Rengasamy	Kansas City	125
Wagman, Armin J	Springfield	082

PDN–PEDIATRIC NEUROLOGY

Tenorio, Gene	Springfield	082

PDP–PEDIATRIC PULMONARY

Rubin, Bruce K	St. Louis	002

PDR–PEDIATRIC RADIOLOGY

Roberts, Fred F	Kansas City	125

PDS–PEDIATRIC SURGERY

Amoury, Raymond A	Kansas City	125
Ashcraft, Keith W	Overland Park	125
Bell, Martin J	St Louis	190
Cradock, Thomas V	St. Louis	190
Danis, Richard K	St. Louis	190
Helikson, Mary A	Columbia	026
Holder, Thos M	Overland Park	125
Murphy, John P	Overland Park	125
Sharp, Ronald J	Overland Park	125
Silen, Mark L	St. Louis	002
Ternberg, Jessie L	St. Louis	190
Weber, Thomas R	St. Louis	190
Zarr, James S	Kansas City	125

PH–PUBLIC HEALTH

Biery, Richard M	Kansas City	125

PM–PHYSICAL MEDICINE & REHABILITAITON

Al-Shathir, Saad	Joplin	102
Conway, Robert R	Columbia	026
Dang, Phung T	St. Louis	190
Garfinkel, Lester S	Kansas City	125
Gettel, Ann H	Kansas City	002
*Guenthner, Brenda L	Jefferson City	058
Kelly, Charles R	Kansas City	125
Komes, Kevin D	Joplin	102
Lennard, Ted A	Springfield	082
Lieb, Thomas F	Clayton	190
Lytle, Edwin L	St. Louis	190
Machek, Otakar	St Louis	190
Mohsen, Aly M	Springfield	082
Peterson, Chas R	Osage Beach	120
Pryor, Harold J	Kansas City	125
Randolph, Bernard C, Jr.	St. Louis	002
Ravi, Latha	St. Louis	002
Samudrala, Suseela	St. Louis	190
Stonnington, Henry H	Columbia	026
Tetalman, Bruce I	St. Joseph	030
Wice, Martin B	St. Louis	190

PS–PLASTIC SURGERY

Abend, Melvin N	Kansas City	125
Barnthouse, Joseph R	Kansas City	125
Bennett, Danny L	Kansas City	125
Brennan, Danl J	St Louis	190
Cabbabe, Edmond B	St. Louis	190
Callegari, Paul R	St. Louis	190
Caplin, David A	St. Louis	190
Coin, Richard E	St. Louis	190
Copeland, Jeffrey G	St. Charles	189
Corwin, Kenneth D	St. Louis	190
Crandall, Richard E	Chesterfield	190
Croll, Gregory H	Columbia	026
Crow, Martin L	Kansas City	125
Danielsson, Ernst P	Springfield	082
DePriest, Michael D	St. Joseph	030
Domann, Darrel D	Springfield	082
Eades, Joseph W	Chesterfield	190
Ettelson, Charles D	Chesterfield	190
Feliciano, Wilfrido C	Maryland Hghts	190
Finley, John M	Joplin	102
Fortin, Don G	Kansas City	050
Francel, Thomas J	St. Louis	002
Garrison, Carla J	Springfield	082
Geraghty, Thomas E	Kansas City	125
Geter, Rodney K	Springfield	082
Goldstein, Marcy A	Pacific Palsade	002
Gutek, E. Philip	Kansas City	125
Halford, Richard M	St. Louis	190
Hart, William G, Jr.	St. Louis	190
Heimburger, Richard A	Columbia	026
Higgs, Philip E	St. Louis	190
Huffaker, William H	Chesterfield	190
Iacobucci, John J	St. Louis	002
Johnson, Charles J	St. Louis	190
Kaplan, Michael F	Columbia	026
Khouri, Roger K	St. Louis	190
Kofkoff, Richard L	Bridgeton	190

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*Doctor of osteopathy.

Kraemer, Bruce A	St. Louis	190
Lakusiewicz, Ronald J	Poplar Bluff	034
Lamb, Jerome P	Blue Springs	125
Lockwood, Ted E	Overland Park	125
Lund, Herluf G, Jr.	Chesterfield	190
MacKinnon, Susan E	St. Louis	190
Marsh, Jeffrey L	St. Louis	190
Marzek, Peter A	St. Louis	002
McGuire, Patricia A	St. Louis	190
Meystrik, Rosellen S	Springfield	082
Mischnick, Carol R	Chesterfield	190
Mosbacher, Hugh E	Lee's Summit	125
Mossie, Raymond D	Gladstone	050
O'Connell, Timothy	St. Louis	190
Onken, Henry D	St Louis	190
Paletta, Christian E	St. Louis	190
Pappalardo, Carlos	St Louis	190
Puckett, Charles L	Columbia	026
Reddy, R. Ramachandra	Cape Girardeau	042
Ribaudo, J. Michael	St. Louis	190
Rinehart, Gregory C	St. Louis	190
Rottler, Paul D	Fenton	190
Ruehl, Albert F	St Louis	190
Scheu, James H	St. Peters	190
Seaberg, John J, III	Columbia	026
Shehadi, Sameer I	St. Louis	190
Sherrod, Duane W	Joplin	102
Shively, Raymond E	St. Louis	190
Strain, Herb A	Kansas City	125
Stromberg, Brent V	St. Louis	190
Swanson, Eric	Kansas City	125
Thompson, Frederick E	Liberty	050
Tobin, Gregory A	Cape Girardeau	042
Waldorf, James C	Kansas City	125
Wall, Norman R	Springfield	082
Walton, Patrick J	Kansas City	125
Webb, Harry E	Kansas City	125
Webber, William B	St Louis	190
Weeks, Paul M	St Louis	190
White, Bruce I	St. Louis	190
Winsky, Arlen D	Springfield	082
Young, Mark E	Kansas City	125
Young, Robert A	Chesterfield	190
Young, Vernon L	St. Louis	190

PTH–PATHOLOGY

Allen, James H	St. Louis	190
Anderson, Douglas A	Springfield	082
Arthaud, J B	Columbia	026
Bari, Wagih A	St. Louis	190
Beatty, Eugene C	Shawnee Mission	125
Benson, Russell L	Lee's Summit	125
Blair, Olga M	St. Louis	190
Bollozos, George D	Chesterfield	190
Bourgeois, Curtis H	Columbia	026
Boyce, John M	Sedalia	178
Brangle, Robt W	St Louis	190
Breckenridge, Robert L	Kansas City	050
Bucher, William C	Columbia	026
Burch, Timothy K	Overland Park	125
Caffrey, Raymond J	Independence	125
Callaway, Lawrence A	Kansas City	125
Carlson, John V	Mexico	014
Carnes, Victor M	Joplin	102
Case, Mary E	St. Louis	190
Caughron, Michael R	Kansas City	125
Cento, Donald	Sikeston	202
Charles, Elaine Z	St. Louis	190
Coffin, Cheryl M	St. Louis	190
Costin, Jimmy L	Poplar Bluff	034
Craver, Jeffrey L	Bridgeton	190
Cummings, Kenneth C	Kansas City	125
Curry, Michael D	Columbia	026
Dehner, Louis P	St. Louis	190
DeFeo, Theodore C	Kansas City	125
Dorzab, William E	Kansas City	125
Duensing, George F	Springfield	082
Dumadag, Virgilio P	St Louis	190
Durr, Jon W	Florissant	190
Esther, John R	Joplin	102
Evans, George A	Columbia	026
Ferris, Charles W, Jr.	St. Louis	190
Fink, Roger L	Springfield	082
Flynn, James M	Kansas City	125
Fritzlen, Thos J	Overland Park	125
Galblum, Larry I	Kansas City	125
Gauthier, Charles P	Kansas City	125
Gerdes, John A	Springfield	082
Givler, Robt L	Kansas City	125
Gresick, Robt J	St Louis	190
Hall, Stanley G	Hannibal	150
Hamel, Peter C	Hannibal	150
Harding, Clarke T	St. Charles	189
Henry, Lawrence D	Columbia	058
Henry, Mary M	Kansas City	125
Hopson, David K	St Louis	190
Horn, Paul C	Cape Girardeau	042
Hurly, Michael P	Joplin	102
Johnson, Gareth R	Independence	125
Johnson, Gordon L	Festus	106
Johnson, Jonathan H	Poplar Bluff	034
Johnson, Steven M	St. Louis	190
Jones, Randall W	Independence	125
Kang, Juan	St. Louis	190
Keitges, Pierre W	Overland Park	125
Kerley, Spencer W	Overland Park	125
King, Gregory S	St. Louis	190
Kissane, John M	St. Louis	190
Kleopfer, Lynn L	Columbia	026
Kraus, Frederick T	St. Louis	190
Landgraf, James R	Columbia	026
Landy, Richard	St. Louis	190
LaBach, James P	Overland Park	125
Lewis, Noel R	Springfield	082
Liao, Kun T	St. Louis	190
Lombardo, Joseph A	St. Louis	190
Marshall, Hal E	Kansas City	125
McDonald, Margaret E	Joplin	102
McIntire, Timothy L	Jefferson City	058
McMeekin, Sheila P	Overland Park	125
Millet, Ruth E	Kansas City	125
Morrison, R. Gideon	Sedalia	178
Mosby, Larry D	Columbia	026
Moya, Carlos E	St. Joseph	030
Mueller, John J	St. Louis	190
Nomura, Roy M	St Louis	190
O'Kell, Richard T	Kansas City	125
Ost, Mark D	Kansas City	125
Paez, Mauro A	St. Louis	190
Patrick, Roman L	St. Louis	190
Perez, Blanca M	St. Louis	190
Perna, Vincent P	St. Louis	189
Pittman, David L	Columbia	026
Pittman, Gerald R	St. Louis	190
Plous, Ronley H	Kansas City	125
Poger, Marshall E	St. Louis	190
Prey, Marianne U	St. Louis	190
Qazi, Nasreen	St. Louis	190
Rao, Sumati	St. Louis	190
Rawson, Perry G	Washington	074
Rippey, John H	Kansas City	125
Rollo, John L	St. Louis	190
Salvador, Antonio	St. Louis	190
Santillano, Antonio B	St Louis	190
Seitz, Elson F	Independence	125
Shah, Sheila	St. Joseph	030
Short, Charles D	St. Louis	190
Siegel, Carl D	Kansas City	125
Silliman, York E	St. Joseph	030
Slahorek, George J	Ft Leonard Wood	135
Smid, David M	Springfield	082
Somoza, Jose R	Kansas City	050
Spollen, Linda E	Columbia	026
Stahr, William D	Cape Girardeau	042
Sueper, Robert H	St. Louis	190
Swank, Darrell	Joplin	102
Talbott, Lawrence B	Kansas City	125
Tombridge, Thomas L	Springfield	082
Tsai, Cheng C	St. Louis	002
Turgeon, Ronald P	St. Louis	190

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Vergara, Gerardo G	Kansas City	125
Villanueva, Angela A	Overland Park	125
Wachter, Ronald M	Springfield	082
Zacharias, Sara	Columbia	026

'UD-PULMONARY DISEASE

Beller, Thomas A	Kansas City	125
Bower, James S	Kansas City	125
Brabson, John H	Springfield	082
Bradley, James K	Kansas City	002
Brook, Charles J	Kansas City	125
Coulter, James W	Springfield	082
Devins, George S	Kansas City	125
Devins, Sidney S	Kansas City	002
Goheen, John R	Kansas City	125
Hargis, James L	Springfield	082
Harrison, Garth F	Kansas City	125
Heinz, George	Springfield	082
Hof, David G	Kansas City	125
Kapitan, Kent S	Kansas City	125
Khan, Khalid I	Cape Girardeau	042
King, John V, Jr.	Ballwin	190
Lampton, Lawrence M	Columbia	026
Lerner, Scott A	Kansas City	125
Pingleton, William W	Shawnee Mission	050
Reddy, Anchala N	West Plains	206
Scacewater, Rick	Joplin	102
Schlozman, Danl L	Kansas City	125
Seto, Takeshi	Kansas City	125
Siler, Thomas M	St. Charles	189
Spence, Thomas H, Jr.	St. Louis	190
*Thomas, Norvin E	Mexico	014
Trombold, Walter S	Kansas City	125
Waxman, Michael J	Kansas City	125
Wiant, James R	St. Louis	190
Wood, John A	Chesterfield	190

R-RADIOLOGY

Abodeely, Daniel A	St. Louis	190
Al-Aly, Robert M	St. Louis	190
Albritton, Michael A	Springfield	082
Anderson, Dixie J	St. Louis	190
Archer, Carol R	St. Louis	002
Augustin, Cesar	St. Louis	190
Bardsley, John L	St Louis	190
Bartholomew, Kenneth K	Quincy	002
Baskurt, Mehmet V	Poplar Bluff	034
Baula, Armindo G	St. Louis	190
Berni, Anthony A	St Louis	190
Blackwell, Chas W	Columbia	026
Borders, Jeffrey L	Kansas City	002
Busse, Paul P	St. Louis	190
Cabal, Edito	St. Louis	190
Campbell, William S, Jr	Cape Girardeau	042
Carls, Garry L	Imperial	190
Clouse, John W	Springfield	082
Cohen, Edward	St. Louis	190
Colbert, Robt S	Sikeston	202
Cook, Marvin	St Louis	190
Courter, Larry P	Osage Beach	058
Cowan, John H	Overland Park	125
Davidson, Kendrick C	Leawood	125
Dehner, Jonathan D	St. Louis	190
Destouet, Judy	Baltimore	190
DeMotte, Jeanne M	Richmond	118
Diemer, David P	St. Louis	190
Diemer, Peter A	St. Louis	190
*Ditzel, Douglas W	Joplin	102
Dixon, Geo D	Kansas City	125
Drisko, Jeanne A	Prairie Village	125
Egan, Thos F	St Louis	190
Ely, Norman B	Springfield	082
Ernst, Richard E	Bridgeton	190
Every, Pamela D	Cape Girardeau	042
Farkas, James R	Sedalia	178
Fisher, Jos L	St. Joseph	030
Francisco, Dominic S	St. Louis	190
Gerdes, K. Eric	Springfield	082
Gilula, Louis A	St. Louis	190
Gonzalez, Mario G	Warrensburg	110
Goodman, Douglas E	Springfield	082
Graviss, Christopher P	Richmond Hghts	002
Greenberg, Benjamin E	Forsyth	208
Gubin, Barry A	Kansas City	125
Gujarati, Subhash B	Poplar Bluff	034
Gustafson, Jon E	Lee's Summit	125
Habert, Edward R	Clarkson Valley	190
Hardy, Jeffery A	St. Louis	190
Hartwig, Raymond W	Overland Park	125
Hawkins, Calvin D	Springfield	082
Hesker, Albert E	Chesterfield	190
Higgins, Michael D	Cape Girardeau	042
Hoskins, R. Bruce	Kansas City	125
Hughes, Douglas W	Overland Park	125
Jablonski, Raymond C	St. Louis	190
Jamroz, Greg A	Washington	074
Johnson, E D, III	Cape Girardeau	042
Johnson, Joy A	Kansas City	125
Judd, Jeffrey B	St. Louis	190
Kays, Kenneth M	Moberly	046
Kennedy, Timothy D	Overland Park	125
Kester, Nathan L	Springfield	082
Kim, Stanley W	St. Louis	190
Kotner, Lawrence M, Jr.	St. Louis	190
Krahn, Henry C	Springfield	082
Krain, Samuel	St Louis	190
Kunz, Stephen R	Overland Park	125
LacKamp, Robert J	St. Joseph	030
Lang, John J	St Louis	190
Leary, Daniel J	St. Louis	190
Lenzenhuber, Karl J	Washington	074
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Link, Alexander J	St Louis	190
Litzow, Peter L	St. Louis	190
Logie, Macdonald B	St. Louis	190
Ludwig, William D	Springfield	082
Machefsky, Sidney D	St. Charles	190
MacDonald, Robt R, Jr.	St. Louis	190
MacNaughton, Ralph E	Kansas City	125
MacNaughton, Robert A, II	Liberty	050
Mais, Thomas E	Shawnee Mission	125
Martin, David S	Chesterfield	190
Massey, Vickie	Kansas City	125
McCown, Allan H	St. Louis	190
Meegan, Robt J	Overland Park	125
Miller, Geoffrey W	St. Louis	190
Moolsintong, Pornchai	St. Louis	190
Nemec, Edward S	St. Louis	190
Nepute, James A	St. Louis	190
O'Brien, Edward J, Jr.	St Louis	190
Orsay, Paul K	St. Louis	190
Pacheco, Jose M	Springfield	082
Pal, Michelle L	Kansas City	125
Parikh, Smita S	Florissant	190
Paskar, Larry D	Chesterfield	190
Pepper, Edward G	St Louis	190
Perez, Carlos A	St Louis	190
Perkins, David E	St. Louis	190
*Pfautsch, Mark L	Cape Girardeau	042
Prater, Kimberley A	Springfield	082
Rabushka, Sanford E	St. Louis	190
Rall, Kenneth L	Independence	026
Regier, Carl M	Palm City	208
Reh, Thos E	St Louis	190
Rezvani, Laghaieh	Sikeston	202
Ritter, Carl F	Cape Girardeau	042
Roehrs, David H	Sedalia	178
Rose, John F	Chillicothe	078
Rozen, Jay I	Kansas City	125
Savci, Hasan D.	St Louis	190
Schmidt, Dennis A	St Louis	190
Schulz, Richard C	St Louis	190
Shaikun, Gerald L	St. Charles	190
Shields, John B	St. Louis	190
Shyken, Herman	St. Louis	190
Smeltzer, Frederick M	Osage Beach	120
Smith, Robert W	St Louis	190
Spalding, Donald G	St. Louis	190
Spector, Gene W	St. Louis	190
Srivisal, Somnuk	St. Louis	190

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Thierauf, Charles G	190	St. Louis
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Trevor, Richard P	125	Kansas City
Verde, Julian N	190	St. Louis
Vijungco, Jose G	190	St. Louis
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Weyman, Philip J	190	Chesterfield
Williams, Craig W	042	Cape Girardeau
Zeigler, Jos M	190	St. Louis
Zobel, Mark S	002	St. Louis
Zukowski, Edward T	190	Chesterfield

REM-REPRODUCTIVE ENDOCRINOLOGY

Lyles, Rodney	125	Overland Park
Starks, Gregory C	125	Kansas City

RHU-RHEUMATOLOGY

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Baldassare, Andrew R	002	St. Louis
Fischbein, Lewis C	190	St. Louis
Huston, Kent A	125	Kansas City
Kincaid, William L	190	St. Louis
Layle, John K, Jr.	125	Kansas City
Schwartz, Howard R	082	Springfield
Taylor, Philip W	042	Cape Girardeau

RO-RADIATION ONCOLOGY

Baglan, Robert J	190	St. Louis
Bedwinek, John M	190	St. Louis
Bruso, Charles E	030	St. Joseph
Cozad, Scott C	125	Kansas City
Devineni, V. Rao	190	St. Louis
Garcia, Delia M	190	St. Louis
Lee, Fransiska A	190	St. Louis
Lin, Hsiu-San	190	St. Louis
Myers, Duane E	102	Joplin
Roy, Tapankumar S	190	St. Louis
Simpson, Joseph R	190	St. Louis
Sutphen, Eric J	190	St. Louis
Walz, Bruce J	190	St. Louis
Zivnuska, Frederick R	190	St. Louis

TR-RADIATION THERAPY

Abadir, Rushdy	026	Columbia
Alcancia, Elpidio Y	082	Springfield
Boles, Murray	026	Columbia
Chaudhury, Triptesh K	002	Port Arthur
Cohen, Joel N	082	Springfield
Crotty, John P	190	St. Louis
Hanes, Lily A	190	Golden Eagle
Mill, Wm B, Jr.	190	St. Louis
Miller, Gayle P	125	Kansas City
Morrison, Richard A	125	Shawnee Mission
Murrell, H. Jerry	026	Columbia
Paradelo, Jorge C	125	Kansas City
Rogers, Joseph Drewry	082	Springfield
Throne, Ben J	125	Kansas City
Tio, Liep T	206	West Plains
Westgate, Steven J	026	Columbia

TS-THORACIC SURGERY

Ashcraft, Walter C	106	Crystal City
Avery, David M	082	Springfield
Bergmann, Martin	190	St. Louis
Coordes, Cordie C	190	Chesterfield
Cox, James L	190	St. Louis
Demmy, Todd L	026	Columbia
Early, Gerald L	030	St. Joseph
Fiore, Andrew C	190	St. Louis
Gallion, Terry L	002	Prairie Village
Garrett, Ted E	190	St. Louis
Graham, Joseph E	190	St. Louis
Gurucharri, Vincent P	026	Columbia
Huddleston, Charles B	190	St. Louis
Johnson, Fritz M	082	Springfield
Judd, Donald R	190	St. Louis
Kaiser, George C	190	St. Louis
Killen, Duncan A	125	Kansas City
Kouchoukos, Nicholas T	190	St. Louis
Kraeger, Russell R	190	St Louis
Leidenfrost, Ronald D	190	Chesterfield
Marbarger, John P, Jr.	190	St. Louis
McDonald, Herbert L	002	Bolivar
Murphy, J. Peter , Jr.	190	St. Louis
Murphy, Michael C	190	St. Louis
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Pennington, D. Glenn	190	St. Louis
Piehler, Jeffrey M	125	Kansas City
Pinkerton, Joe A, Jr.	125	Kansas City
Ramsey, J. Darryl	042	Cape Girardeau
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Roberts, Shauna R	030	St. Joseph
Rogers, James D	082	Springfield
Roper, Charles L	190	St Louis
Ruess, Robert W	042	Cape Girardeau
Russell, James L	125	Kansas City
Sasser, Wm F	190	St. Louis
Sauer, Paul E	082	Springfield
See, W. Mike	026	Columbia
Seligson, Frederic L	125	Prairie Village
Shaw, Richard C	190	St Louis
Stamatis, John J	082	Springfield
Stephenson, Hugh E	026	Columbia
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Vest, James C	190	St. Louis
Wathanacharoen, Suchint	125	Kansas City
Williams, Robert D	050	Kansas City
Willman, Vallee L	190	St. Louis

U-UROLOGY

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Ahmann, Thomas M	014	Mexico
Aldridge, George A	034	Poplar Bluff
Apte, Sunil M	074	Washington
Austin, George M	125	Blue Springs
Avallone, Anthony N	082	Springfield
Basler, Joseph W	190	Crestwood
Biber, Robert J	125	Independence
Bigg, Steven W	190	St. Louis
Blades, Ross D	082	Springfield
Blath, Richard A	190	St. Louis
Bock, David B	125	Kansas City
Boullier, John A	190	St. Louis
Bowles, Wm T	190	St Louis
Boyarsky, Saul	190	St. Louis
Brehm, G. Scott	102	Joplin
Brennan, Robt V	190	St. Louis
Brodkey, Mark J	125	Kansas City
Bussmann, Donald W, Jr	082	Springfield
Carpenter, James L	189	St. Charles
Chehval, Micheal J	190	St Louis
Cummings, James M	190	St. Louis
Deleste, Carlos J	106	Festus
Denes, Bela	190	Bridgeton
DeGuerre, Ronald K	190	Chesterfield
Elkins, Robert L	125	Kansas City
Ellis, Harry L	082	Springfield
Emeran, George J	190	St. Louis
Falzone, John J	058	Jefferson City
Farber, Barry S	082	Springfield
Fathman, Anthony E	190	Chesterfield
Feit, Robert M	190	St. Louis
Felker, J. Russell	042	Cape Girardeau
Foster, R. Steve	178	Sedalia
Freiden, Floyd J	125	Kansas City
Frogge, Jim D	102	Joplin
Fuleihan, Farid M	190	St. Louis
Gelstein, Laurence D	190	St. Louis
Gonzales, Jose H	174	Perryville
Grim, Edward M	102	Joplin
*Hall, John P	042	Cape Girardeau
Hardy, David A	190	St. Louis
Harrin, Wm R	125	Kansas City
Harrison, Winston E	026	Columbia

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Hawatmeh, Ibrahim S	St. Louis	190
Herrick, Thomas B	Kansas City	050
Houttuin, Erik	Washington	106
Itoku, Kendall	Chesterfield	190
Johnson, Jeffrey R	Springfield	082
Johnson, Robert D	Springfield	082
Jones, Jace S	Springfield	082
Killion, Linza T	Kansas City	125
Klein, Saul J	St. Louis	190
Kozminski, Mike	St. Joseph	030
Kurtz, Karl J	Kansas City	125
Leifer, Gary	Kansas City	125
Lentz, Harold C, Jr.	Independence	125
Lierz, Mark F	Kansas City	125
Lovinggood, J. Perry	St. Louis	190
Mackey, Richard L	St. Louis	002
Madduri, Sivaprasad D	Poplar Bluff	034
Mahboubi, Aziz O	Sikeston	202
Maloney, Robert M	St. Louis	190
Manion, Thos S	Independence	125
Marcus, Michael D	St. Louis	190
McCanse, Lynn R	N. Kansas City	050
Mehan, Donald J	St. Louis	190
Milne, Jay L	Springfield	082
Mitchell, John D	Kansas City	125
Moeller, Randall J	St. Joseph	030
Moore, Jack D	Kansas City	125
Morgan, Willy J C	E. St. Louis	190
Myers, Geo H	Kansas City	125
Neuman, Neal	St. Louis	190
Nicolai, Chas H	St. Louis	190
Parra, Raul O	St. Louis	190
Parres, Jeffrey A	St. Louis	190
Partamian, Krikor O	St. Joseph	030
Pearson, Thomas C	Springfield	082
Perinetti, Enrique P	St. Louis	190
Petros, John A	University City	002
Powell, Edwin M	Springfield	082
Prophete, Yves R	St. Louis	190
Rader, Edward S	St. Louis	190
Reddy, Abbiah N	Poplar Bluff	034
Remis, Robert E	St. Joseph	030
Ross, Gilbert , Jr.	Columbia	026
Saha, Nitai C	St. Louis	190
*Scanlon, Robert C, II	Springfield	082
Scheibe, Robert G	St. Louis	190
Schermer, Jerrold A	Columbia	026
Schmidt, Jerome H	Jefferson City	058
Scully, Thomas F	St. Louis	190
Shah, Jitendra P	St. Louis	190
Shands, Courtney , III	St. Louis	190
Silber, Sherman J	Chesterfield	190
Steinhardt, George F	St. Louis	190
Sunshine, Herbert	St Louis	190
Terry, James F	Springfield	082
Thompson, Paul D	Cape Girardeau	042
Torrence, Ralph J	Bridgeton	190
Wan, Shaw P	Rolla	135
Weaver, Dana J	Columbia	026
Webb, James P	Springfield	082
Weide, Allan R	N. Kansas City	050
Weinberger, Phillip C	Higginsville	118
Weinstein, Stephen H	Columbia	026
West, James C, Jr.	Kansas City	125
Wise, Morris F	Kansas City	125

VS–VASCULAR SURGERY

Auer, Arthur I	St Louis	190
Barbee, Chas W	Columbia	026
Bass, Barry J	Rolla	135
Dunn, David B	Liberty	050
Henzel, John H	Columbia	026
Higgins, Edward F, JR	Kansas City	125
Hurley, Joseph J	St. Louis	190
James, Paul M, Jr.	Kansas City	125
Nichols, W. Kirt	Columbia	026
Ostrow, Bridget F	Cape Girardeau	042
Silver, Donald	Columbia	026
Stark, Karl R	Kansas City	125
Thompson, Robert W	St. Louis	190
Vogel, Curt M	Columbia	026
Walker, Howard S	St. Louis	190

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Huff, Carla
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Levin, Michael
Liang, Griffith E
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*Doctor of osteopathy.

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Stacy, Gregory S
Starr, Ann
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Strawhecker, Kristin
Sun, John C
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Trump, Nichol M
Truong, Rosalie M
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AI	**Allergy & Immunology**
ALI	Allergy & Immunology/Diagnostic Laboratory Immunology
AN	**Anesthesiology**
CCA	Anesthesiology, Critical Care
APM	**Anesthesiology, Pain Management**
CD	Cardiovascular Disease
CCM	**Critical Care Medicine**
D	Dermatology
DMP	**Dermatopathology**
DDL	Dermatological Immunology/Diagnostic Laboratory Immunology
DIA	**Diabetes**
EM	Emergency Medicine
END	**Endocrinology**
FPS	Facial Plastic Surgery, Otolaryngology
FP	**Family Practice**
FPG	Family Practice, Geriatric Medicine
FSM	**Family Practice, Sports Medicine**
GE	Gastroenterology
GP	**General Practice**
GO	Gynecological Oncology
GYN	**Gynecology**
HEM	Hematology
IG	**Immunology**
ID	Infectious Diseases
IM	**Internal Medicine**
ICE	Internal Medicine, Cardiac Electrophysiology
ILI	**Internal Medicine/Diagnostic Laboratory Immunology**
IMG	Internal Medicine, Geriatrics
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NSP	Neurology, Pediatric Surgery
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OMO	Orthopedic Surgery, Musculoskeletal Oncology
OP	**Orthopedic Surgery, Pediatric Orthopedics**
OSM	Orthopedic Surgery, Sports Medicine
OSS	**Orthopedic Surgery, Spine Surgery**
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PTH	Pathology, Anatomic/Clinical
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PCH	Pathology, Chemical
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RIP	Pathology, Radioisotopic
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CCP	Pediatric Critical Care
PLI	**Pediatric/Diagnostic Laboratory Immunology**
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PDE	**Pediatric Endocrinology**
PG	Pediatric Gastroenterology
PHO	**Pediatric Hematology-Oncology**
PN	Pediatric Nephrology
PDP	**Pediatric Pulmonology**
PA	Pharmacology, Clinical
PM	**Physical Medicine & Rehabilitation**
HSP	Plastic Surgery, Hand Surgery
GPM	**Preventive Medicine, General**
P	Psychiatry
CHP	**Psychiatry, Child**
PYG	Psychiatry, Geriatric
PYA	**Psychoanalysis**
PH	Public Health
PUD	**Pulmonary Disease**
RO	Radiation Oncology
R	**Radiology**
DR	Radiology, Diagnostic
PDR	**Radiology, Pediatric**
TR	Radiology, therapeutic
VIR	**Radiology, Vascular and Interventional**
REM	Reproductive Endocrinology
RHU	**Rheumatology**
AS	Surgery, Abdominal
CDS	**Surgery, Cardiovascular**
CRS	Surgery, Colon & Rectal
CCS	**Surgery, Critical Care**
GS	Surgery, General
HNS	**Surgery, Head & Neck**
NS	Surgery, Neurological
ORS	**Surgery, Orthopedic**
PDS	Surgery, Pediatric
PS	**Surgery, Plastic**
TS	Surgery, Thoracic
TRS	**Surgery, Traumatic**
U	Surgery, Urological
VS	**Surgery, Vascular**
UM	Undersea Medicine
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Breast of chicken

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of chicken breast

Today's Pork: Compare it to chicken for a healthy surprise

You may not have considered pork to be a healthy choice for your patients on fat-modified diets. But today's fresh pork compares surprisingly well to chicken in total fat, saturated fat, cholesterol, and calories.[1,2*]

	Calories	Total Fat	Saturated Fatty Acids	Cholesterol
Chicken Breast, skinless	140	3.0 g	0.9 g	72 mg
Pork Tenderloin, trimmed	139	4.1 g	1.4 g	67 mg
Pork Top Loin Roast (boneless), trimmed	165	6.1 g	2.2 g	66 mg
Center Loin Chop, trimmed	172	6.9 g	2.5 g	70 mg
Chicken Thigh, skinless	178	9.2 g	2.6 g	81 mg

*Table refers to 3-oz, cooked servings.

Missouri Pork Producers Association
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of pork tenderloin

New study: Pork is now 31% leaner

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Today's pork fits well within the dietary guidelines recommended by both the American Heart Association and the National Cholesterol Education Program. Here's some advice to help patients on low-fat diets enjoy the variety, extra taste, and versatility of pork:

- Choose the leanest cuts. Shop for cuts with "loin" in the name.
- Trim away any visible fat.
- Keep portions moderate (about 3 oz, cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.

1. US Dept of Agriculture. *Composition of Foods: Pork Products*, 1991. Agricultural handbook 8-10.
2. US Dept of Agriculture. *Composition of Foods: Poultry Products*, 1979. Agricultural handbook 8-5.

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✓ Monitored over 1300 bills submitted during the 1993 General Assembly of the Missouri Legislature.

✓ Helped to defeat scores of terrible legislative proposals that would have created socialized medicine in Missouri, legalized lay midwifery, granted prescriptive authority to nurses, granted admitting privileges to psychologists and much, much more.

✓ Helped to enact a comprehensive health care reform law that will improve health care access to more than 600,000 Missourians.

✓ Helped to expand the State Legal Expense Fund to cover physicians, physician assistants, nurses, and dentists who provide free, primary care to indigent patients in Missouri.

✓ Provided counsel to the State's 34 Senators and 163 Representatives on medical issues as they met to consider health care legislation.

✓ Maintained the highly effective "Key Contact" network that encourages physicians across the state to stay in close contact with their lawmakers.

✓ Maintained contact with Missouri's Congressional Delegation as they considered a number of federal bills, rules and regulations.

✓ Monitored the fortnightly **Missouri Register** for any new regulations concerning health care that may have been issued by a government agency.

✓ Represented your interests at numerous public hearings on a variety of medical issues.

✓ Revised the MSMA's **Model Hospital Medical Staff Bylaws** that has received widespread recognition and acceptance by medical staff members working in hospitals throughout the United States.

✓ Represented your interests at meetings of the Missouri PRO board.

✓ Assisted over 40 physicians through the Missouri Physicians Health Program.

✓ Monitored and approved CME accreditation for a dozen institutions in Missouri.

✓ Provided CME course work for 18 specialties during the MSMA's 1993 Annual Meeting at Tan-Tar-A.

✓ Sponsored several practice management workshops for physicians and office staff members at locations around the state.

✓ Helped manage the self-funded Missouri State Medical Foundation which will provide over $450,000 in loans this year to approximately 125 Missouri medical school students.

✓ Published six issues of **Missouri Medicine,** the Journal of the Missouri State Medical Association.

✓ Published **Progress Notes**, a monthly newsletter designed to keep you and your colleagues abreast of current events that affect your profession and practices.

✓ Responded to numerous requests for information from journalists.

✓ Sent periodic **Medical Messages** to every newspaper in the state, plus 150 Missouri businesses.

✓ Supported the MSMA Physician Placement Service which matches interested physicians with communities seeking qualified applicants.

✓ Filed amicus briefs in several important court cases dealing with various medical-legal issues.

✓ Participated in the AMA's Risk Management Program.

✓ Reactivated the MSMA's Blue Ribbon Committee on professional liability and tort reform to address vital tort reform issues.

✓ Sponsored the MSMA's Hospital Medical Staff Section which exists to assist hospital staff physicians in dealing with administrators and boards of trustees.

✓ Began development of an MSMA videotape program for television broadcast that features Missouri physicians discussing medical matters.

✓ Funded the Medical Practice Research Center to study patient outcomes and practice variations on several procedures to provide physicians with valuable data regarding usage rates and practice guidelines.

✓ Created a physicians group to advise Healthcare Interchange, an electronic claims clearinghouse.

✓ Represented you on the Medicare Part B Carrier Advisory Committee, providing input into the creation of medical policies.

✓ Created physicians' guidelines for interacting with patients covered under Americans With Disabilities Act (ADA).

✓ Worked extensively on the implementation of the CLIA regulations to make them as flexible as possible.

✓ Published a step-by-step manual for physician compliance with OSHA's bloodborne pathogen regulation.

. . . and the year is only half gone!

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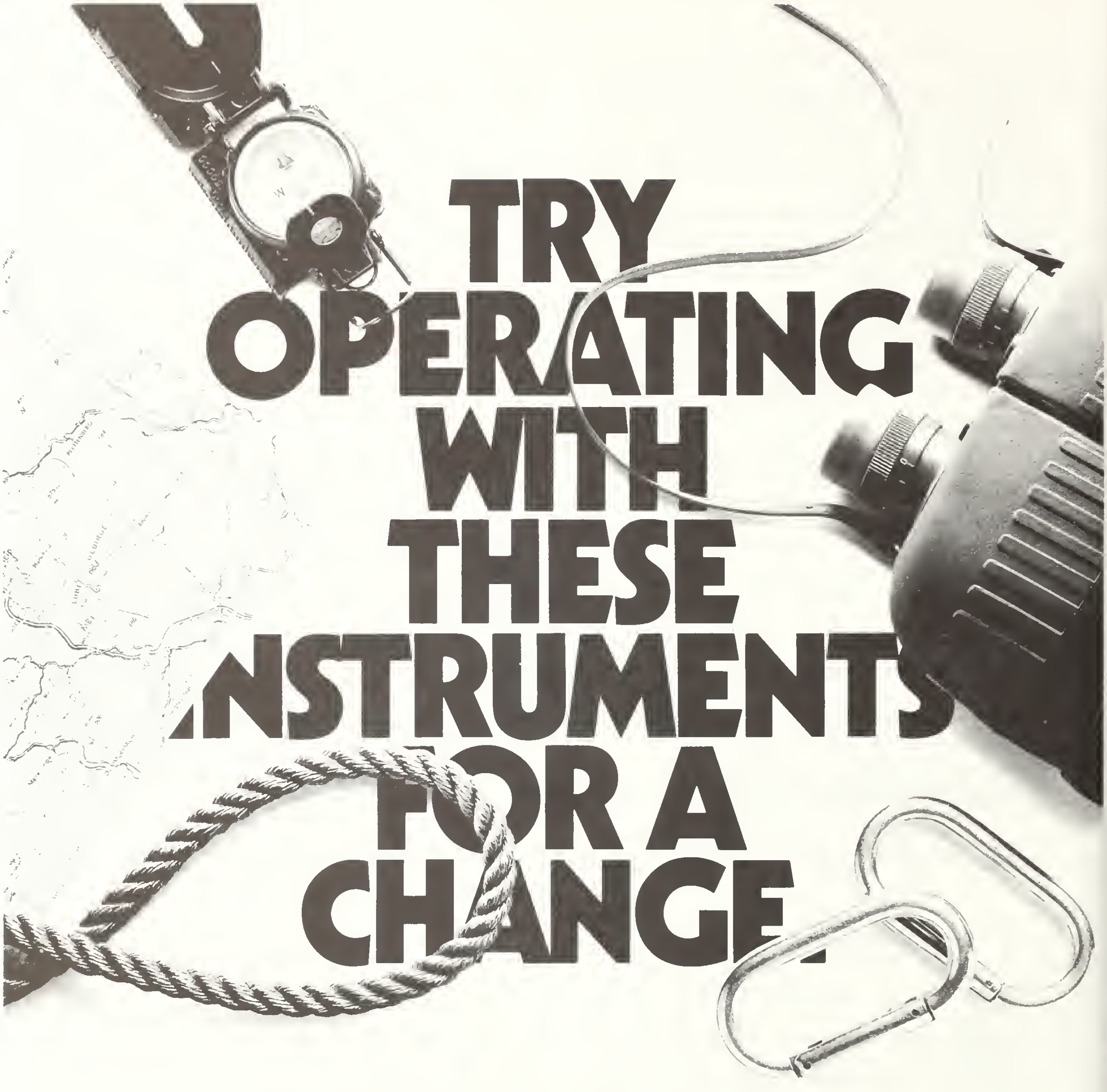

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YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.
Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.
Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.
Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.
Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]
How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.
References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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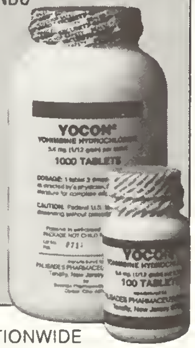

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Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991,14:146-151.

PRAVACHOL® (Pravastatin Sodium Tablets)

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SO 31,906). A small increase was seen in mean AUC values and half-life (t1/2) for the inactive enzymatic ring hydroxylation metabolite (SO 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine. The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SO 31,906 and SO 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SO 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*, a forward mutation assay in L5178Y TK +/− mouse lymphoma cells, a chromosomal aberration test in hamster cells, and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area ($mg/meter^2$). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS. **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions. An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma, anorexia, vomiting.

Reproductive. gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS. **Skeletal Muscle** and PRECAUTIONS. **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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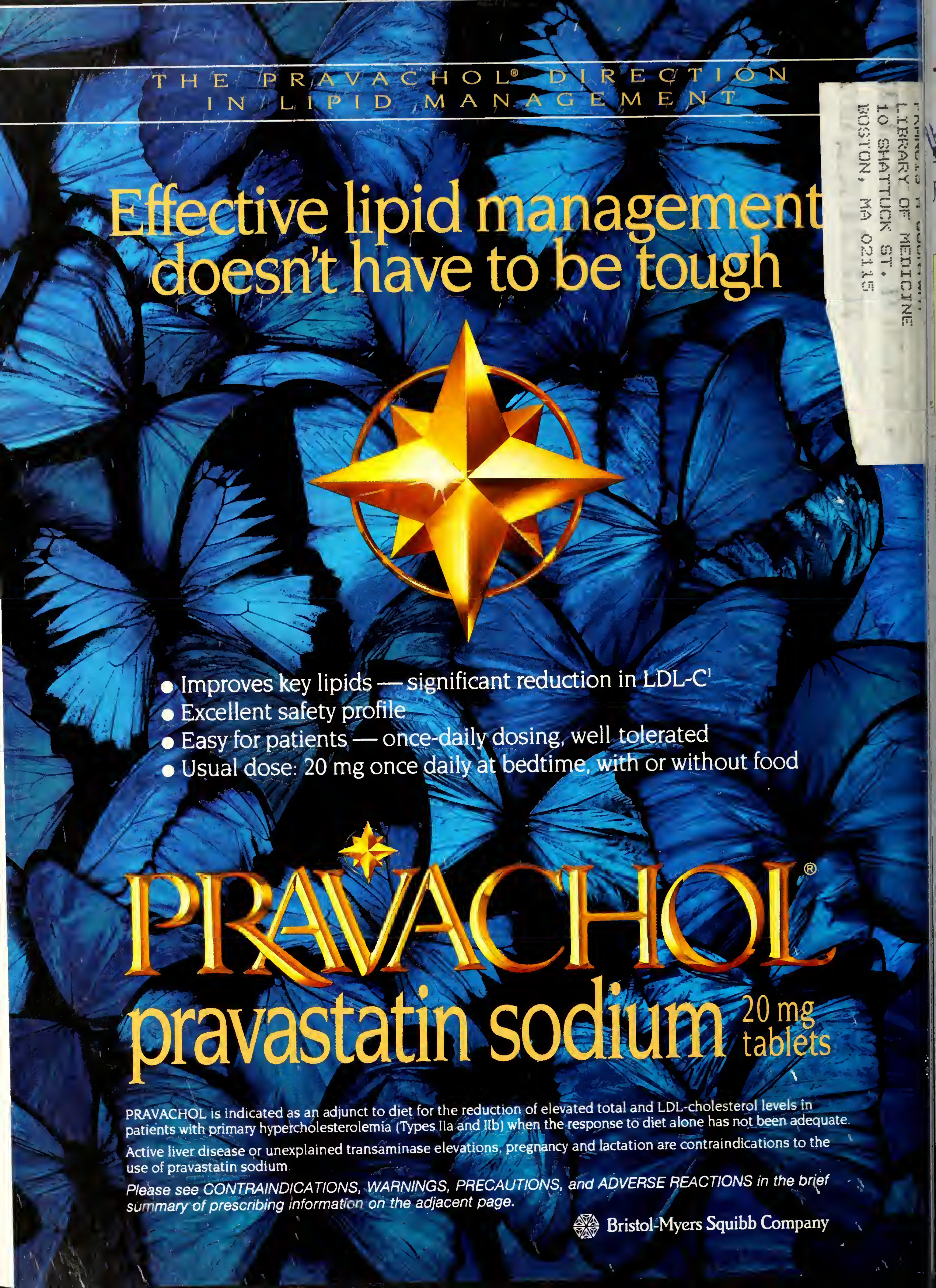

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PRAVACHOL is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate.

Active liver disease or unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of pravastatin sodium.

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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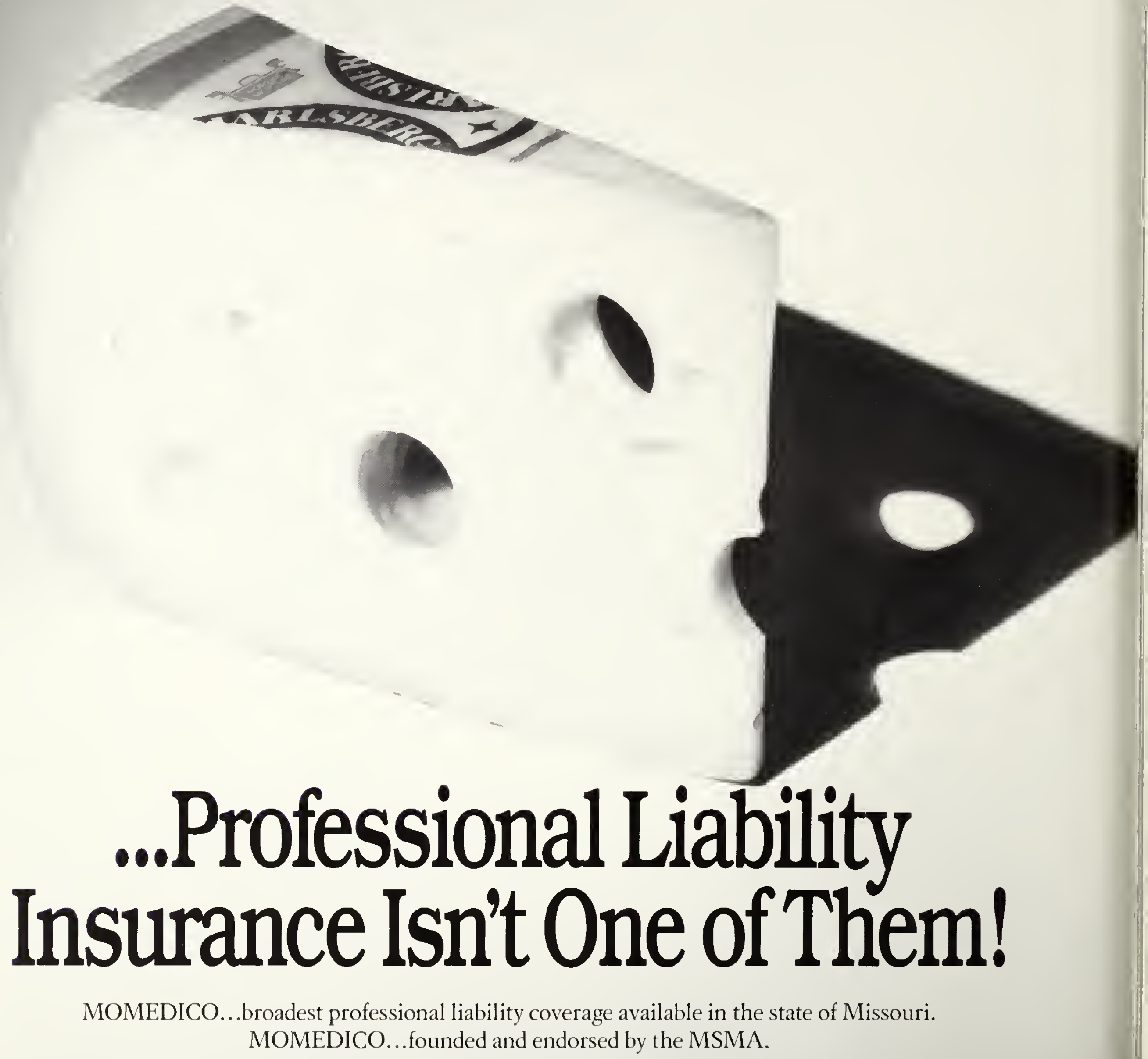

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September Cover

Phil Schroeder of Jefferson City has worked for the Department of Natural Resources for the past 13 years. He is the 1993 Trout Stamp Competition winner. Mr. Schroeder, not an artist by trade, wanted the opportunity to exhibit his work locally and did not expect to win. The painting is of an area on the Current River downstream from Akers Ferry.

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THE FLOOD of '93

J. Regan Thomas, MD

It is ironic that with all the discussion about how health care policy and delivery may change, the various administration health "plans," or the changing relationships of hospitals and physicians (i.e. PHO's), the biggest impact on our practices may be something as mundane as the weather.

With two major rivers swollen beyond record levels, Missouri is the state hardest hit by the Flood of '93. As rain continued beyond the biblical forty days and nights, the impact on our communities became more abundantly clear. Swollen rivers and tributaries began to invade areas that did not traditionally think of themselves as "river towns." Dry bed creeks and run off areas saturated neighborhoods that sometimes did not even realize a creek was there until it encroached upon their doorstep. Now several weeks later, it is estimated over 500 square miles of Missouri land remains flooded. At the time of this writing, property damage and crop losses are placed at $4 billion. Presently an interstate highway is closed and several major state highways are still under water. Only one bridge across the Missouri River between Kansas City and St. Charles is open, and several bridges across the Mississippi north of St. Louis remain closed.

I had the opportunity to accompany the crew of *Good Morning America* from ABC TV news as they reported the flood and televised their show from St. Louis. Their press credentials allowed us to cross barricade lines and see first-hand some of the flood damage and the attempts to control the uncontrollable. Talking with people, as we viewed the river invading their homes and property provided a dramatic perspective on the real life impact of this calamity. The experience reinforced the sense of relief that my own home and family were in an area which was not at risk.

All of us to some degree will share in the effects of the Flood of '93 however. There will no doubt be prolonged and significant impact on the community's economy and no doubt will influence medical practices. Those of you living outside the flood areas will likely feel the effects of the flood as certain agricultural costs are reflected at the supermarket. It may also be reflected in increased costs of certain manufactured goods from the many companies and factories located along the major rivers. It certainly will affect your insurance costs as insurance companies try to spread and amortize their losses over a greater client pool.

As physicians, the public health aspects related to the flood will require our skills, recognition, and empathy. Immediate concerns have already included health problems related to trauma, for example, injuries stemming from chronic use problems like back and musculoskeletal injuries acquired during building sandbag levies. Drowning and near drowning episodes have occurred with alarming frequency. Dehydration and heat-related maladies were commonplace concerns.

We now will be faced with the psychological trauma and depression that understandably will haunt those losing homes and property. These difficulties will be prolonged even as the flood waters recede and the damage becomes more evident. The enormous clean-up difficulties will not make the task of returning to normal lives less problematic.

More chronic health difficulties may continue to present problems in a prolonged fashion. Hepatitis looms as a real concern as contaminated water saturates everything in its path. Vermin, including snakes, have invaded homes and property in attempts to avoid the high water. Snake bites have increased in St. Louis emergency rooms and may further increase as clean-up begins. Acres of standing water is a bonanza for mosquitoes. Insect vector problems, including encephalitis, are a real possibility. Public health officials say that the next years "hatch" may even actually be worse than this year.

As we discuss and ponder these problems, it is interesting to hear various views on the cause of the situation. Some are convinced that a higher being is punishing us for riverboat gambling (I suppose the Burger King boat being destroyed was to warn against the evils of fast food.) More worldly complaints focus on the Corps of Engineers and what certain individuals feel was a misdirected flood control plan. Others less eloquently espouse the philosophy seen on bumper stickers from time to time that reads, "S___ Happens."

Whatever the cause, periodically we are reminded that we have relatively little control over the truly major events of the world. Our battles and concerns over more workaday banal issues seem less momentous by comparison. As physicians, we are perhaps more aware of the frailties of the human condition than our fellow citizens. As physicians, we should assume a role beyond our own offices and practice environment to guide and support our communities through these difficult times.

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The Name Game: Getting Into Those "Impossible to Get Into" Colleges

John C. Hagan III, MD

"You mean you're turning down a chance to go to Harvard?" the incredulous recruiter stammered. "Nobody turns down Harvard."

"Don't take it personally," my daughter Cathy said, "I just don't like Boston. I'm going to Stanford."

This exchange ended our daughters' successful efforts to gain admission to universities that almost everyone had said were "impossible to get into." It would be presumptuous to think that my wife and I got Cathy accepted into Stanford and Harvard or our other daughter, Carol, into Wesleyan and later a PhD program at Penn. Their own hard work and intelligence were the most important factors. Nevertheless after spending the last seven years sweating through the admissions process of some of America's most competitive schools there are some things that we wish we knew at the beginning of this odyssey. I will share some suggestions that may help those of you with children seeking éclat as well as an education by applying to America's educationally "elite" colleges and universities.

Hard Core Parenting by Both Spouses

A stable two parent family may be the most important factor in producing stellar students. An astounding 86% of today's Ivy League students were raised in two-parent homes. (*U.S. News and World Report*, April 12, 1993) The two parent household statistically is the most economically advantaged, has the lowest incidence of juvenile delinquency and the highest levels of academic achievement. A stable home environment free of discord, hate, alcohol and drug abuse is the most important factor in helping your child develop into a confident, independent, well-adjusted adult. Children need and deserve the love, attention and support of *both* their parents. Children should have a male and female parent to serve as role models for their development. The demands of medicine cannot and should not be used by the physician parent to opt out of an active role. During and after a divorce there is an even greater need for both parents to remain active and attentive to the child's development and not involve the child in the acrimony that often attends the dissolution of a marriage.

The Author: John C. Hagan III, MD, is an Ophthalmologist practicing in North Kansas City.

Creating an Intellectual Atmosphere

This should take many forms. The child needs to learn that an inquiring mind is a desirable attribute. The child's natural curiosity needs stimulation and direction. Encourage reading. Make interesting books available including reference works. Buy an encyclopedia. Expose children early to the Arts and classical music. Take them to museums, concerts, theatre and good cinema. Visit historical places and different areas of the country. For family recreation play Jeopardy, Trivial Pursuit and other "thinking games." Encourage the verbal and written use of vocabulary expanding words. Television infrequently contributes to intellectual growth. Limit, monitor and direct "tube time." This is the computer age. Buy a computer early, learn educational programs and word processing with your child. Make sure the computer is used for more than games. Keep your own mind active and stimulated. Study something besides medicine. Scholarship begets scholarship. Forty percent of mothers and sixty percent of fathers of Ivy Leaguers have done graduate study, triple the rate at non-competitive colleges.

Choosing the Right Prep Schools

This is one of the most difficult choices parents have to make. The choices are public, parochial or private schools and alternative education including parental teaching. Much of American education on the primary, secondary and high school levels is in turmoil. The decline in school performance as measured by standardized tests is a national disgrace and has yet to be addressed in a constructive manner. Many schools are used as holding areas for disadvantaged, hostile students with no inclination to learn. The chances of scholarship flourishing in such an atmosphere is remote. Public schools often vary dramatically in quality from district to district depending on finances, leadership and demographics. Many districts have failed to pass necessary tax levies to support their school systems. Sadly, in some districts the public schools simply will not provide quality college preparatory education. After much deliberation we chose public schools for both our daughters. Our North Kansas City school district is rated triple A and we knew that the best students were regularly accepted into competitive schools. The school district was one of the main factors in our choice of a neighborhood to live. Private schools are more expensive and not available in every location. Many of them have excellent curricula, fine teachers and good records of placing their students in elite universities. Because of their selective and

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competitive nature the best private schools may better prepare the student for the more intense demands and competition of college. Forty percent of the Ivies' freshmen went to private schools. For families with strong religious beliefs parochial schools may offer many of the advantages of private schools coupled with religious indoctrination. The personality of the student is also a factor. Some students will thrive in the public school environment while others will be bewildered and in need of personal attention not available in large classes. I have no knowledge or experience with alternative education such as "home school." I doubt that it is a practical alternative for most physicians.

Saving for College

The cost of a year at Stanford is now $23,500 and rising faster than inflation. In today's technologically advanced world a bachelors degree is not sufficient for competency or to guarantee marketable skills. Our children will need master's and doctorate degrees even post-doctoral fellowships. Most studies of physicians' incomes indicate reductions from historical levels are likely. Planning and education designated savings should begin while the child is very young. Professional financial planning is often beneficial. I used the vehicle of a Clifford Trust which allowed significant tax savings on the money put aside for our daughters' education. The financial help of grandparents is an increasingly important source of educational money. Expert estate planning is very important to transfer money from generation to generation without incurring horrific estate taxes. Out of necessity many top institutions, such as Brown University, are abandoning the "need blind" admissions process. This means, other things being equal, the student able to pay for the education will be accepted before a student needing financial assistance.

Building an Attractive Curriculum Vitae

Outstanding grades and class rank will not always guarantee acceptance at a competitive university but poor grades and low class standing will almost always guarantee a rejection. A great CV is built on stellar grades and challenging courses. Stanford could fill their entire Freshman class with straight A students yet only 36% of straight A applicants were admitted. Many applicants with lower grade point averages were accepted. These schools are so selective that good scholarship is taken for granted. Admissions boards are looking for unique individuals with special talents. Sports, extracurricular activities, musical skills and student leadership are important. Excelling on the local, state and national level in debate, forensics, sports and music are a definite plus. Depth of accomplishment rather than breadth is preferred by most admissions boards. Avoid being a Jack of all trades - master of none. Foreign exchange programs with study abroad and fluency in a foreign language will distinguish an application form. Most schools are impressed by a summer spent doing something other than lifeguarding or baby-sitting. Music and Space camps, Outward Bound Courses, Earth Watch and Sierra Club projects and unusual, interesting summer jobs or preceptorships are looked on favorably. Admissions boards seek the individual with a "social conscience," so volunteer work, membership in service organizations and tutoring the disadvantaged are a plus.

Doing Well in Acheivement Tests

The Scholastic Aptitude Test (SAT) and American College Test (ACT) scores are one of the most important predictors of a successful admission process. Admissions boards use them to measure achievement and native intelligence. High schools differ in their grading techniques and the rigor of their academic standards. The achievement tests allow direct comparisons among the applicant pool. Good scores (>1300 SAT combined score and >28 ACT score) reinforce a scholarly image. Poor scores will have to be heavily counterbalanced by grades, course work, essays and other areas of the application process. It is generally accepted that SAT preparatory courses do improve test scores. Our daughter took the Kaplan course after taking the Preliminary SAT (PSAT). The improvement was well worth the expense and I strongly recommend them. Also available for study to prepare for the tests are textbooks, computer software programs and purchase of old SAT tests. Students can take the achievement tests several times and send the best scores with their applications.

Finding the Right University

Among the 75-100 most selective colleges there is tremendous diversity. College is for kids not parents. Never force a child to apply to a school that does not interest them. Each university has its own unique personality. There must be a match between the student's personality and that of the school. The student that thrives at Duke may be totally bewildered at Berkeley and vice versa. Many choices exist: such as size (Michigan vs Amherst), urban or rural location (University of Chicago vs Dartmouth), small liberal arts college vs research university (Williams vs M.I.T.) There are excellent sources of factual information on colleges, faculties, student demographics and the "personality" of the university. Among the best are: *The Fisk Guide to Colleges*, *The Insider's Guide to the Colleges*, *U.S. News & World Report's College Guide to America's Best Colleges* and *Barron's Guide to the Best, Most Popular and Most Exciting Colleges*. Be sure to get the most recent edition. Read the college's own promotional brochures and attend their local college nights and recruiter visits. High school guidance counselors are not a very good source of information being usually overburdened and uninformed.

Typical college admission requirements and required courses should be reviewed early in the high school years to insure proper selection of important elective high school courses. Serious and selective choice of colleges usually begins in the high school Junior and Senior years. Students should consider as many schools as practical but apply only to those that seriously interest them. Each application is a job in itself and will require considerable time and effort. Most advisors recommend application to about 6-10 schools. A typical list would include three or four extremely competitive schools, two or three less competitive and at least two where the student would be satisfied to go and admission is highly likely. Be sure each application is complete, check spelling and grammar. The application is no place for modesty. Applicants should strut their stuff and highlight those skills, accomplishments and goals that will set them apart from the other applicants. Check with the college admissions office to be sure the application is complete.

If a student has a strong preference for one school an "early acceptance" application should be considered. This process differs slightly from school to school. The salient feature is that the school will make an early decision on an applicant in return for a guarantee that if admission is offered the student will accept. The applications for this early decision program are usually filed in mid-November to early December of the senior year of high school. Notifications are completed by the end of December. If the student does not receive "early acceptance" they are still eligible for regular acceptance and can apply elsewhere.

Visiting the most appealing schools is highly desirable. It is ideal for parents to accompany the child on these trips. Most schools offer student led tours and question and answer seminars (talk, tour and meal) with admission officers. These visits will allow the opportunity to visit with students who are usually very candid and open about the strengths and weaknesses of the school.

Essays, Interviews, Letters of Recommendation

Interviews have been downgraded in importance at most schools. But an interview remains very desirable. A bad interview will probably not hurt but a good interview will boost borderline applications. Most schools will arrange for an interview by a local alum. If an interview is desired during a visit submit requests early. Prepare for the interview. Ask intelligent questions and express an interest in the school. Don't ask factual questions that are answered in the school catalog. Essays have increased in importance. The essay is considered a vehicle for the applicant to demonstrate writing skills, imagination as well as present facets of their personality not reflected in other parts of the application. The essays should be given much time and effort. Parents should resist the urge to ghostwrite or over-edit the essay. The essay might be proofread for spelling and grammar errors by a supportive teacher but the final product should be from the applicant. For an idea of what makes for outstanding essays read *Essays That Worked: 50 Essays from Successful Applications to the Nation's Top Colleges* (Kampmann and Co.). Also read "Letters of Recommendations" an article from *English Journal* (1987;76:32-34) by Marguerite Kownslar.

Equality of Applicants

Selective colleges have never been meritocracies. For many years a "Good Old Boy" network insured the almost exclusive admission of white, Anglo-Saxon Protestant men of "proper" social standing. Blatant discrimination kept women, Jews, Catholics, Blacks and other minorities from being admitted. In recent years many of these barriers and discriminatory practices have been eliminated. Women now represent 46% of Ivy league students, Catholics 24%, Jews 27%, Asians 17% and Blacks 7%. Affirmative action, i.e. the lowering of admission standards and preferential selection still is used at most schools for minorities, intercollegiate athletes, children of major benefactors and to a lesser extent to promote a broad geographic representation. This latter factor will usually work to the advantage of Missouri applicants, except at Washington University in St. Louis. Other things being equal a Midwest applicant will be given preference at Princeton over an East Coast student to give geographic diversity. The largest number of preferential admissions are given to "legacies." These are children who have a parent that attended the university. Twenty percent of Harvard's admissions over the last 40 years have been given preference because they were legacies even though studies have shown the average legacy is significantly less qualified than accepted non-legacies. At many schools the SAT and ACT scores of legacies, athletes and some minorities are omitted from tabulating the scores of freshmen students so as not to lower the average. If there is an alumni connection to a school it should be exploited. A student that has a strong interest in a field especially one that has trouble attracting enough applicants e.g. women in engineering, may contact department heads who will sometimes help the student in the admission process.

Commercial Academic Counselors

Fierce competition and the intricacies of the college application process has spawned a new professional: an independent college consultant. These scholastic coaches specialize in putting together the most attractive application package money can buy. They offer help with choice of schools, interviews and essays. Their services run from hourly fees of $50-$75/hr up to $3,000 packages. For further information contact the National Association of College Admission Counselors (703-863-2222) and the Independent Education Consultants Association (617-477-2127). Student use of this type of service is increasing and many such advisors like to sign up students in the eighth grade to allow more time to shape the child's record.

Nothing and no-one can guarantee acceptance into an elite university. The United States has the finest university system in the world. An excellent education can be had for a fraction of the cost at the University of Missouri-Columbia and literally hundreds of other less competitive colleges in all parts of the country. That however is not the purpose of this article. With tens of thousands of highly qualified students trying to get into the same 75-100 schools, students and parents need to think positively but realistically, give the application process their best shot, deal with rejections philosophically and take the best choice offered. Good Luck!

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Data is driving health care decisions...
Be Wise - Know Your Data

Danielle Halsel

THE PROBLEM

Ramifications of practice profile analyses done by Medicare and private insurance carriers is far-reaching. Their ability to generate and analyze claims data is rapidly expanding. Depending on the carrier's mission and philosophy, coupled with its sophistication of data and retrieval, one will see a wide array of uses for this information, for example:

- Audits are being triggered if the distribution of codes does not fall within the claims history or the "guidelines" set by the carriers. If profiles exist which *cannot* be explained via the carrier's expectation or data base, the possibility of audit increases. Consequences of an audit can range from education to penalty to exclusion from the network.
- Credentialing of providers, particularly in managed care plans, is being done, in part, through analysis of claims data. Judgements about the cost-effectiveness of care are being made based on comparatives between similar specialties' profiles. As managed care plans become more selective they will retain only those physicians who deliver high-quality, cost-effective providers. Part of the "proof" of this illusive standard, and adherence to it, will be done through data analysis.
- Norms and standards of care are being established using data obtained through the claims files. Ultimately, these can be used to judge care given by the physician. Careful analysis of the data must be routinely and periodically checked for validity and accuracy, particularly as they pertain to a specific practice or specialty.

Whether or not the practice's pattern stays within a given "norm," the individual patient record documentation should support both the code chosen and the medical necessity of the visit. The practice should periodically review medical record documentation to ensure documentation meets the standards for the code assigned.

THE SOLUTION

The frequency report (also called the production summary) is the logical starting place to carefully analyze all data the practice generates.

Analyze the distribution of E/M codes:

- specific to each physician within the practice, and
- relational to the all physicians within the practice, and
- comparative to billing in other similar practices.

The ratio of codes should be reflective of the type of patients in your practice (the "case mix"). Additionally, the documentation for the visits should meet the standards as outlined in CPT-4 1993. The following should be analyzed through the frequency report at least quarterly:

Office-based Visit Codes

- *Distribution of all office-based service codes*
Most practices should use ***all*** of the codes within the new and established patient code groups; and the distribution should approximate your practice's case mix. Appropriate documentation is absolutely necessary to support the evaluation and management codes.

- *Ratio of new patients to established patients*
The number of new patients entering the practice can be a valid indicator of the practice's growth. The ratio between the number of visits coded as "new" versus "established" can be a valuable tool to a practice who intends to grow. Practices committed to adding new patients will have a lower ratio (1 new patient seen for every 15 established patients) than an established closed-practice (1:40). This statistic should be gathered and reviewed on a quarterly basis.

- *Use of code 99211 ("nursing" visit)*
The percentage of visits within the category needs to be reviewed to ensure; 1) the practice is using and billing for nursing visits appropriately, and 2) physicians are *not* billing using this code.

Continued on page 575

E/M FREQUENCY REPORT ANALYSIS

CPT CODE		DESCRIPTOR	PHYSICIAN		PRACTICE	
			#	%	#	%
New Patient OV	99201	OV - New - Problem Focused				
	99202	OV - New - Expanded Problem				
	99203	OV - New - Detailed				
	99204	OV - New - Comprehensive				
	99205	OV - New - Comprehensive				
Est Patient OV	99211	OV - Est - Minimal				
	99212	OV - Est - Problem Focused				
	99213	OV - Est - Expanded				
	99214	OV - Est - Detailed				
	99215	OV - Est - Comprehensive				
Office Consultations	99241	OC -New/Est - Straightforward				
	99242	OC - New/Est - Expanded				
	99243	OC - New/Est - Detailed				
	99244	OC - New/Est - Moderate				
	99245	OC - New/Est - High				
Initial Hospital Care	99221	Initial HC - Low Complexity				
	99222	Initial HC - Moderate				
	99223	Initial HC - High Complexity				
Subsequent HC	99231	Subsequent HC - Low				
	99232	Subsequent HC - Moderate				
	99233	Subsequent HC - High				
Discharge Day	99238	Hospital DD Management				
Inpatient Consult	99251	Initial IP Cons - Straightforward				
	99252	Initial IP Cons - Expanded				
	99253	Initial IP Cons - Low				
	99254	Initial IP Cons - Moderate				
	99255	Initial IP Cons - High				

Physician ________________________

Time - Frame ________________________

Continued from page 573

Hospital-based Visit Codes

▼ *Distribution of all hospital-based service codes*

As with office-based services, virtually all of the initial hospital care and subsequent hospital care code levels should be used. Distribution among these codes should be relational to the patients' acuity, time spent and corresponding documentation.

▼ *Ratio of the number of initial hospital codes and discharge codes*

The ratio of initial hospital care codes and discharge day management codes is expected to be close to, but not exactly 1:1, because the discharge day management of a deceased patient is often billed under subsequent hospital care codes, and allowances are not made for patients who are hospitalized by one physician and subsequently transferred to the care of another.

▼ *Average length of hospital patient stay*

Generally speaking, the average length of stay of the hospitalized patient can be determined by adding the number of initial hospital care codes, subsequent hospital care codes and discharge day management codes billed and dividing by the number of initial hospital care codes billed. This ratio does not take into account patients for whom critical care billing was done or when one practice admits and another discharges a patient.

These are only a few of the ratios which your practice should be regularly scheduling for review and evaluation.

If you have questions for Danielle Halsel, write to Practice Management, c/o ***Missouri Medicine****, PO Box 1028, Jefferson City, MO 65102 or call her at (913) 541-0050.*

To use the reporting form featured on page 574, fill in your practice's volumes in each category for any time-frame you choose (e.g. the last six months of 1992) and also the volumes for each physician in your practice for the same period of time. Determine the total volume within each category of codes (new OV, established OV, consults, etc.), and then determine the percent distribution of each individual code within the range. Repeat this process quarterly.

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Today's Pork: Compare it to chicken for a healthy surprise

You may not have considered pork to be a healthy choice for your patients on fat-modified diets. But today's fresh pork compares surprisingly well to chicken in total fat, saturated fat, cholesterol, and calories.[1,2]*

	Calories	Total Fat	Saturated Fatty Acids	Cholesterol
Chicken Breast, skinless	140	3.0 g	0.9 g	72 mg
Pork Tenderloin, trimmed	139	4.1 g	1.4 g	67 mg
Pork Top Loin Roast (boneless), trimmed	165	6.1 g	2.2 g	66 mg
Center Loin Chop, trimmed	172	6.9 g	2.5 g	70 mg
Chicken Thigh, skinless	178	9.2 g	2.6 g	81 mg

*Table refers to 3-oz. cooked servings.

Missouri Pork Producers Association
Route 11, 6235 Cunningham Drive
Columbia, Missouri 65202-9162
(314) 445-8375

New study: Pork is now 31% leaner

Pork is leaner today because of significant changes made in breeding and feeding techniques. According to new 1991 official USDA data, fresh pork sold today contains an average of 31% less fat after cooking and trimming than the same pork cuts reported in 1983.[1]

Today's pork fits well within the dietary guidelines recommended by both the American Heart Association and the National Cholesterol Education Program. Here's some advice to help patients on low-fat diets enjoy the variety, extra taste, and versatility of pork:

- Choose the leanest cuts. Shop for cuts with "loin" in the name.
- Trim away any visible fat.
- Keep portions moderate (about 3 oz, cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.

[1] US Dept of Agriculture. *Composition of Foods: Pork Products*, 1991. Agricultural handbook 8-10.

[2] US Dept of Agriculture. *Composition of Foods: Poultry Products*, 1979. Agricultural handbook 8-5.

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LETTERS TO THE EDITOR

Dear Dr. Kent Walker,

Just got my copy of *Missouri Medicine*, May 1993. I write to compliment you and your associates on the Dermatology Quiz articles. The #4 Erythema Multiforme one is especially good.

Thank you. Keep up this good series.

Gordon C. Sauer, MD
Kansas City, Missouri

Written to Dr. Ash in regard to the article, "The Use of Rectal Temperature to Monitor Heat Stroke," published in *Missouri Medicine*, May 1992.

Dear Dr. Charles Ash,

I am very pleased to tell you that this year's pilgrimage to mecca is over with a very encouraging breakthrough. Our team applied a strategy, where we abandoned external body cooling, but employed internal colling via cold IV inufsion, and, at the same time, minimized reliance on rectal temperativer as recovery parameter. The credit for the latter part is yours, and we are thankful to you. The combination of these two factors was very rewarding, in that: 1) no shivering was observed, and 2) cooling time was reduced by more than half (from 2-3 hours last year, to 45 minutes-1 hour this year).

Your letter of May 3, 1993, arrived in time for this year's event, and I tried to apply pulse rate monitoring during cooling of heat stroke victims, but there does not seem to be a specific trend which could be traced. Whether this is a function of the rapid effect of cold IV infusion vs conventional cooling procedures, remains to be seen.

Yours Sincerely,
Dr. Amin Kashmeery
Organizing Committee Chairman
Umm Al-Qura University, Saudi Arabia

In Defense of the Prostatic Specific Antigen (PSA) Screening

First, let me introduce myself: I am a 57-year-old general surgeon who practices north of Kansas City. In May, 1992, at age 55, purely on a whim, I elected to have a PSA drawn. The results were 10 nanograms per milliliter. With this elevated positive laboratory study, a transrectal ultrasound of the prostate was done which showed asymmetry of the gland. Random four quadrant needle biopsies were obtained. On one microscopic field, there were findings that were difficult to interpret and the slides were forwarded to the Armed Forces Institute of Pathology who returned the diagnosis of a well differentiated carcinoma of the prostate. I was symptom free, had a normal digital rectal examination, and no specific findings on ultrasound; however, I had an elevated PSA and a positive biopsy of a low grade carcinoma of the prostate.

After considerable thought and consultations from many sources, we elected to simply "wait and watch" with the thesis that many men my age had exactly the same situation. The game plan was to repeat the digital rectal exam, ultrasound and biopsy in six months. These studies were thus obtained. The PSA was unchanged at 10 nanograms per milliliter, the ultrasound exam was essentially the same; however the needle biopsies were not difficult to read showing a well differentiated carcinoma of the prostate. I remained digital rectal exam normal and symptom free.

Six months later, May 1993, the transrectal ultrasound showed a definable lesion and the PSA was elevated to 13. The needle biopsies now showed a moderately differentiated carcinoma which was a more worrisome reading. I remained symptom free with a normal digital exam.

The media this summer is in hyperactivity on how to treat prostate carcinoma; however, they are pitifully short of specific details. Each case must be considered as to age, life expectancy, complications and general health demands. I elected a radical suprapubic prostatectomy with pelvic lymph node dissection. This procedure was performed in June 1993, and as of this writing I am some six weeks postoperative. The final pathology report showed a moderately differentiated carcinoma approaching the capsule but not invading. There was no seminal vesical involvement and no lymph node involvement. My surgeons and I are hopeful that this will be a cure.

I have become absolute in the opinion that the PSA brought me to the recommended treatment that may very well have saved my life in regard to metastatic prostate carcinoma.

So, in conclusion, please don't let third party payors influence you from taking good care of your patients or yourselves. PSA screening for the appropriate candidate should definitely be an insurance covered test.

Thomas H. Hendren, MD, FACS
Liberty, Missouri

DOES YOUR SPOUSE KNOW?

Joan H'Doubler

A one of a kind opportunity is easily within your reach! It offers support at a time when issues concerning physicians and their spouses are hitting closer to home than ever before.

The MSMA Alliance is reaching out to you, the male or female spouse of a physician, encouraging you to share in the benefits, resources, and solutions which are yours with membership.

Do you know that as a member you will be an informed partner in medicine?

Publications such as AMAA's *FACETS*, and our state *Alliance Report* will keep you updated on what is happening in medicine across the United States and in Missouri. Medical family concerns, health topics, and timely issues are addressed. We provide a vehicle for your voice to be added to a unified voice; one which is making an impact on the legislative process affecting the medical profession, and subsequently the medical family.

Do you know that membership in the Alliance offers you unlimited opportunities for both career and personal growth?

Benefits include leadership training, educational seminars as well as the chance to update your skills and experience within a group who will appreciate them. You can establish a computerized record of your professional, volunteer, and educational experience with profiles upon request. Tangible benefits include special rates on car rentals and hotel rooms, a member VISA Card, insurance policies and investment services.

Do you know that we are revitalizing our organization to move with the changing times?

The nationwide name change from Auxiliary to Alliance is the culmination of a lengthy and thoughtful assessment of who we are, what we do, and how we are perceived. The term Alliance more clearly communicates who we are - partners with medicine, sharing perspectives, and traveling down the same road. The tagline "Physicians' spouses dedicated to the health of Missouri" explains what we do - create community awareness of today's health issues, and help children, teens, adults, and seniors lead healthier lives.

As a male spouse, are you aware that the male Alliance member is now an active participant in legislative and health education activities across our nation?

We urge you to take this opportunity to meet and enjoy a new challenge; establish peer relationships and professional contacts; and to feel the satisfaction of relating better to the medical community.

Do you know that if you live in a community where there is not an organized medical Alliance you can become a member-at-large?

You will be warmly welcomed at state and organized county meetings, seminars and social events.

Enjoy the empathy and camaraderie of membership while serving as a very important resource for health-related information in your community. We need you!

The MSMA Alliance is a multi-faceted organization. It is made up of articulate, knowledgeable people who choose to give their own time to the education and health of the nation.

Whether the choice is made to be actively involved or to be a supportive member of Alliance efforts, there is one choice!

BE A MEMBER!

Discover The Elegance Of A Hybrid

At first glance, it's the *beauty* of a rose that catches the eye. The vibrant color. The delicately shaped petals. But study it more closely, and its *elegance* becomes apparent—a gentle blend of softness and strength.

At first glance, it's the *enhanced performance* of Vaseretic that catches the eye. But study Vaseretic more closely, and its *elegance* becomes apparent. The way its one-tablet, once-a-day dosage minimizes multiple medications. Minimizes insurance copayments. And minimizes potassium supplementation.

A hybrid *blending of tolerability and power* that's available for the right patient. Vaseretic is indicated for the treatment of hypertension in patients for whom combination therapy is appropriate.

And an elegant discovery for your practice.

USE IN PREGNANCY: When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, Vaseretic® (Enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, *Fetal/Neonatal Morbidity and Mortality.*

VASERETIC® 10-25
Enalapril Maleate-Hydrochlorothiazide

Next

Dosage must be individualized; the fixed combination is not for initial therapy.

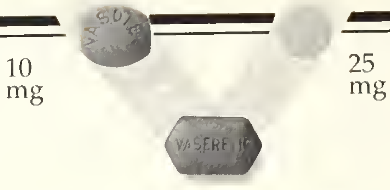
Evaluation of the hypertensive patient should always include assessment of renal function.

For a Brief Summary of Prescribing Information, see adjacent pages.

TABLETS

VASERETIC®

(ENALAPRIL MALEATE-HYDROCHLOROTHIAZIDE)



USE IN PREGNANCY: When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC® (Enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, *Fetal/Neonatal Morbidity and Mortality*.

CONTRAINDICATIONS: VASERETIC is contraindicated in patients who are hypersensitive to any component of this product and in patients with a history of angioedema related to previous treatment with an angiotensin converting enzyme inhibitor. Because of the hydrochlorothiazide component, this product is contraindicated in patients with anuria or hypersensitivity to other sulfonamide-derived drugs.

WARNINGS: *General; Enalapril Maleate; Hypotension:* Excessive hypotension was rarely seen in uncomplicated hypertensive patients but is a possible consequence of enalapril use in severely salt/volume depleted persons such as those treated vigorously with diuretics or patients on dialysis.

Syncope has been reported in 1.3 percent of patients receiving VASERETIC. In patients receiving enalapril alone, the incidence of syncope is 0.5 percent. The overall incidence of syncope may be reduced by proper titration of the individual components. (See PRECAUTIONS, *Drug Interactions*, and ADVERSE REACTIONS.)

In patients with severe congestive heart failure, with or without associated renal insufficiency, excessive hypotension has been observed and may be associated with oliguria and/or progressive azotemia, and rarely with acute renal failure and/or death. Because of the potential fall in blood pressure in these patients, therapy should be started under very close medical supervision. Such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart or cerebrovascular disease, in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses, which usually can be given without difficulty once the blood pressure has increased after volume expansion.

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis and/or larynx has been reported in patients treated with angiotensin converting enzyme inhibitors, including enalapril. In such cases VASERETIC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis or larynx, likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided.** (See ADVERSE REACTIONS.)

Patients with a history of angioedema unrelated to ACE inhibitor therapy may be at increased risk of angioedema while receiving an ACE inhibitor (see also CONTRAINDICATIONS).

Neutropenia/Agranulocytosis: Another angiotensin converting enzyme inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Lithium generally should not be given with thiazides (see PRECAUTIONS, *Drug Interactions, Enalapril Maleate and Hydrochlorothiazide).*

Pregnancy; Enalapril-Hydrochlorothiazide: There was no teratogenicity in rats given up to 90 mg/kg/day of enalapril (150 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose) or in mice given up to 30 mg/kg/day of enalapril (50 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose). At these doses, fetotoxicity expressed as a decrease in average fetal weight occurred in both species. No fetotoxicity occurred at lower doses, 30/10 mg/kg/day of enalapril-hydrochlorothiazide in rats and 10/10 mg/kg/day of enalapril-hydrochlorothiazide in mice.

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC should be discontinued as soon as possible. (See *Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality*, below.)

Enalapril Maleate; Fetal/Neonatal Morbidity and Mortality: ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of VASERETIC as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment.

If oligohydramnios is observed, VASERETIC should be discontinued unless it is considered lifesaving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means of reversing hypotension and/or substituting for disordered renal function. Enalapril, which crosses the placenta, has been removed from neonatal circulation by peritoneal dialysis with some clinical benefit, and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure.

No teratogenic effects of enalapril were seen in studies of pregnant rats, and rabbits. On a mg/kg basis, the doses used were up to 333 times (in rats), and 50 times (in rabbits) the maximum recommended human dose.

Hydrochlorothiazide; Teratogenic Effects: Reproduction studies in the rabbit, the mouse and the rat at doses up to 100 mg/kg/day (50 times the human dose) showed no evidence of external abnormalities of the fetus due to hydrochlorothiazide. Hydrochlorothiazide given in a two-litter study in rats at doses of 4 - 5. 6 mg/kg/day (approximately 1 - 2 times the usual daily human dose) did not impair fertility or produce birth abnormalities in the offspring. Thiazides cross the placental barrier and appear in cord blood.

Nonteratogenic Effects: These may include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

PRECAUTIONS: *General; Enalapril Maleate; Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe congestive heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with angiotensin converting enzyme inhibitors, including enalapril, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20 percent of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent pre-existing renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when enalapril has been given concomitantly with a diuretic. This is more likely to occur in patients with pre-existing renal impairment. Dosage reduction of enalapril and/or discontinuation of the diuretic may be required.

Evaluation of the hypertensive patient should always include assessment of renal function.

Hemodialysis Patients: Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes (e.g., AN 69*) and treated concomitantly with an ACE inhibitor. In these patients consideration should be given to using a different type of dialysis membrane or a different class of antihypertensive agent.

Hyperkalemia: Elevated serum potassium (greater than 5.7 mEq/L) was observed in approximately one percent of hypertensive patients in clinical trials treated with enalapril alone. In most cases these were isolated values which resolved despite continued therapy, although hyperkalemia was a cause of discontinuation of therapy in 0.28 percent of hypertensive patients. Hyperkalemia was less frequent (approximately 0.1 percent) in patients treated with enalapril plus hydrochlorothiazide. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with enalapril. (See *Drug Interactions.)*

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Warning signs or symptoms of fluid and electrolyte imbalance, irrespective of cause, include dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, confusion, seizures, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or after prolonged therapy. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia may cause cardiac arrhythmia and may also sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Because enalapril reduces the production of aldosterone, concomitant therapy with enalapril attenuates the diuretic-induced potassium loss (see *Drug Interactions, Agents Increasing Serum Potassium).*

Although any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease), chloride replacement may be required in the treatment of metabolic alkalosis.

Dilutional hyponatremia may occur in edematous patients in hot weather, appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

In diabetic patients dosage adjustments of insulin or oral hypoglycemic agents may be required. Hyperglycemia may occur with thiazide diuretics. Thus latent diabetes mellitus may become manifest during thiazide therapy.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

If progressive renal impairment becomes evident consider withholding or discontinuing diuretic therapy.

Thiazides have been shown to increase the urinary excretion of magnesium; this may result in hypomagnesemia.

Thiazides may decrease urinary calcium excretion. Thiazides may cause intermittent and slight elevation of serum calcium in the absence of known disorders of calcium metabolism. Marked hypercalcemia may be evidence of hidden hyperparathyroidism. Thiazides should be discontinued before carrying out tests for parathyroid function.

Increases in cholesterol and triglyceride levels may be associated with thiazide diuretic therapy.

Information for Patients; Angioedema. Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

Pregnancy: Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

NOTE. As with many other drugs, certain advice to patients being treated with VASERETIC is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions; Enalapril Maleate; Hypotension—Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS.)

Agents Causing Renin Release: The antihypertensive effect of enalapril is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: Enalapril has been used concomitantly with beta adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine and prazosin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: Enalapril attenuates diuretic-induced potassium loss. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia they should be used with caution and with frequent monitoring of serum potassium.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant enalapril and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Hydrochlorothiazide; When administered concurrently the following drugs may interact with thiazide diuretics:

Alcohol, barbiturates, or narcotics—potentiation of orthostatic hypotension may occur.

Antidiabetic drugs (oral agents and insulin)—dosage adjustment of the antidiabetic drug may be required.

Other antihypertensive drugs—additive effect or potentiation.

Cholestyramine and colestipol resins—Cholestyramine and colestipol resins bind the hydrochlorothiazide and reduce its absorption from the gastrointestinal tract by up to 85 and 43 percent, respectively. Thiazides may be administered two to four hours before the resin when the two drugs are used concomitantly.

Corticosteroids, ACTH—intensified electrolyte depletion, particularly hypokalemia.

Pressor amines (e.g., norepinephrine)—possible decreased response to pressor amines but not sufficient to preclude their use.

Skeletal muscle relaxants, nondepolarizing (e.g., tubocurarine)—possible increased responsiveness to the muscle relaxant.

Lithium—should not generally be given with diuretics. Diuretic agents reduce the renal clearance of lithium and add a high risk of lithium toxicity. Refer to the package insert for lithium preparations before use of such preparations with VASERETIC.

Non-steroidal Anti-inflammatory Drugs—In some patients, the administration of a non-steroidal anti-inflammatory agent can reduce the diuretic, natriuretic, and antihypertensive effects of loop, potassium-sparing and thiazide diuretics. Therefore, when VASERETIC and non-steroidal anti-inflammatory agents are used concomitantly, the patient should be observed closely to determine if the desired effect of the diuretic is obtained.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Enalapril in combination with hydrochlorothiazide was not mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril-hydrochlorothiazide did not produce DNA single strand breaks in an *in vitro* alkaline elution assay in rat hepatocytes or chromosomal aberrations in an *in vivo* mouse

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bone marrow assay

Enalapril Maleate There was no evidence of a tumorigenic effect when enalapril was administered for 106 weeks to rats at doses up to 90 mg/kg/day (150 times[*] the maximum daily human dose). Enalapril has also been administered for 94 weeks to male and female mice at doses up to 90 and 180 mg/kg/day, respectively, (150 and 300 times[*] the maximum daily dose for humans) and showed no evidence of carcinogenicity

Neither enalapril maleate nor the active diacid was mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril was also negative in the following genotoxicity studies. rec-assay, reverse mutation assay with *E. coli*, sister chromatid exchange with cultured mammalian cells, and the micronucleus test with mice, as well as in an *in vivo* cytogenic study using mouse bone marrow

There were no adverse effects on reproductive performance in male and female rats treated with 10 to 90 mg/kg/day of enalapril.

Hydrochlorothiazide. Two-year feeding studies in mice and rats conducted under the auspices of the National Toxicology Program (NTP) uncovered no evidence of a carcinogenic potential of hydrochlorothiazide in female mice (at doses of up to approximately 600 mg/kg/day) or in male and female rats (at doses of up to approximately 100 mg/kg/day) The NTP, however, found equivocal evidence for hepatocarcinogenicity in male mice

Hydrochlorothiazide was not genotoxic *in vitro* in the Ames mutagenicity assay of *Salmonella typhimurium* strains TA 98, TA 100, TA 1535, TA 1537, and TA 1538 and in the Chinese Hamster Ovary (CHO) test for chromosomal aberrations, or *in vivo* in assays using mouse germinal cell chromosomes, Chinese hamster bone marrow chromosomes, and the *Drosophila* sex-linked recessive lethal trait gene Positive test results were obtained only in the *in vitro* CHO Sister Chromatid Exchange (clastogenicity) and in the Mouse Lymphoma Cell (mutagenicity) assays, using concentrations of hydrochlorothiazide from 43 to 1300 μg/mL, and in the *Aspergillus nidulans* non-disjunction assay at an unspecified concentration.

Hydrochlorothiazide had no adverse effects on the fertility of mice and rats of either sex in studies wherein these species were exposed, via their diet, to doses of up to 100 and 4 mg/kg, respectively, prior to conception and throughout gestation.

Pregnancy; Pregnancy Categories C (first trimester) *and D* (second and third trimesters). See WARNINGS, *Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.*

Nursing Mothers: Enalapril and enalaprilat are detected in human milk in trace amounts. Thiazides do appear in human milk. Because of the potential for serious reactions in nursing infants from either drug, a decision should be made whether to discontinue nursing or to discontinue VASERETIC, taking into account the importance of the drug to the mother.

Pediatric Use Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: VASERETIC has been evaluated for safety in more than 1500 patients, including over 300 patients treated for one year or more In clinical trials with VASERETIC no adverse experiences peculiar to this combination drug have been observed Adverse experiences that have occurred, have been limited to those that have been previously reported with enalapril or hydrochlorothiazide

The most frequent clinical adverse experiences in controlled trials were dizziness (8.6 percent), headache (5.5 percent), fatigue (3.9 percent) and cough (3.5 percent). Adverse experiences occurring in greater than two percent of patients treated with VASERETIC in controlled clinical trials were: muscle cramps (2.7 percent), nausea (2.5 percent), asthenia (2.4 percent), orthostatic effects (2.3 percent), impotence (2.2 percent), and diarrhea (2.1 percent).

Clinical adverse experiences occurring in 0.5 to 2.0 percent of patients in controlled trials included. *Body As A Whole:* Syncope, chest pain, abdominal pain, *Cardiovascular* Orthostatic hypotension, palpitation, tachycardia, *Digestive* Vomiting, dyspepsia, constipation, flatulence, dry mouth; *Nervous/Psychiatric* Insomnia, nervousness, paresthesia, somnolence, vertigo; *Skin:* Pruritus, rash; *Other*. Dyspnea, gout, back pain, arthralgia, diaphoresis, decreased libido, tinnitus, urinary tract infection.

Angioedema Angioedema has been reported in patients receiving VASERETIC (0.6 percent). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis and/or larynx occurs, treatment with VASERETIC should be discontinued and appropriate therapy instituted immediately (See WARNINGS.)

Hypotension In clinical trials, adverse effects relating to hypotension occurred as follows: hypotension (0.9 percent), orthostatic hypotension (1.5 percent), other orthostatic effects (2.3 percent). In addition syncope occurred in 1.3 percent of patients. (See WARNINGS.)

Cough See PRECAUTIONS, *Cough.*

Clinical Laboratory Test Findings, Serum Electrolytes See PRECAUTIONS

Creatinine, Blood Urea Nitrogen: In controlled clinical trials minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.6 percent of patients with essential hypertension treated with VASERETIC More marked increases have been reported in other enalapril experience. Increases are more likely to occur in patients with renal artery stenosis. (See PRECAUTIONS.)

Serum Uric Acid, Glucose, Magnesium, and Calcium See PRECAUTIONS

Hemoglobin and Hematocrit Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g percent and 1.0 vol percent, respectively) occur frequently in hypertensive patients treated with VASERETIC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1 percent of patients discontinued therapy due to anemia

Liver Function Tests Rarely, elevations of liver enzymes and/or serum bilirubin have occurred.

Other adverse reactions that have been reported with the individual components are listed below and, within each category, are in order of decreasing severity

Enalapril Maleate—Enalapril has been evaluated for safety in more than 10,000 patients. In clinical trials adverse reactions which occurred with enalapril were also seen with VASERETIC. However, since enalapril has been marketed, the following adverse reactions have been reported: *Body As A Whole:* Anaphylactoid reactions (see PRECAUTIONS, *Hemodialysis Patients*); *Cardiovascular* Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high risk patients (see WARNINGS, *Hypotension*); pulmonary embolism and infarction; pulmonary edema, rhythm disturbances including atrial tachycardia and bradycardia, atrial fibrillation; hypotension; angina pectoris, *Digestive* Ileus, pancreatitis, hepatic failure, hepatitis (hepatocellular [proven on rechallenge] or cholestatic jaundice), melena, anorexia, glossitis, stomatitis, dry mouth; *Hematologic:* Rare cases of neutropenia, thrombocytopenia and bone marrow depression, a few cases of hemolysis in patients with G-6-PD deficiency have been reported in which a causal relationship to enalapril cannot be excluded, *Nervous System/Psychiatric:* Depression, confusion, ataxia, peripheral neuropathy (e.g., paresthesia, dysesthesia); *Urogenital* Renal failure, oliguria, renal dysfunction (see PRECAUTIONS), flank pain, gynecomastia; *Respiratory* Pulmonary infiltrates, bronchospasm, pneumonia, bronchitis, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection; *Skin:* Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, alopecia, flushing, photosensitivity; *Special Senses.* Blurred vision, taste alteration, anosmia, conjunctivitis, dry eyes, tearing.

Miscellaneous: A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash and other dermatologic manifestations.

Fetal/Neonatal Morbidity and Mortality See WARNINGS, *Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.*

Hydrochlorothiazide—Body as a Whole Weakness; *Digestive* Pancreatitis, jaundice (intrahepatic cholestatic jaundice), sialadenitis, cramping, gastric irritation, anorexia, *Hematologic:* Aplastic anemia, agranulocytosis, leukopenia, hemolytic anemia, thrombocytopenia, *Hypersensitivity* Purpura, photosensitivity, urticaria, necrotizing angiitis (vasculitis and cutaneous vasculitis), fever, respiratory distress including pneumonitis and pulmonary edema, anaphylactic reactions, *Musculoskeletal* Muscle spasm; *Nervous System/Psychiatric:* Restlessness; *Renal:* Renal failure, renal dysfunction, interstitial nephritis (see WARNINGS); *Skin:* Erythema multiforme including Stevens-Johnson syndrome, exfoliative dermatitis including toxic epidermal necrolysis, alopecia, *Special Senses:* Transient blurred vision, xanthopsia

[*] Based on patient weight of 50 kg

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VARIATIONS IN THREE CARDIOVASCULAR DISEASE RISK FACTORS IN MISSOURI, 1986-1992

Anthony Wilkins, MPH; Sue Dabney, MEd, MPH; Carol A. Smith, MSPH;
Joan C. Wilkerson, BA; Ennis L. McClanahan, BS; Ross C. Brownson, PhD

In 1991, cardiovascular disease claimed the lives of over 22,000 Missourians. Recent studies show that much of this mortality can be eliminated through risk factor reduction and early detection. This article examines the regional and demographic differences in three major cardiovascular disease risk factors and outlines some steps that physicians and other health care providers can take to reduce their prevalence.

INTRODUCTION

During the 20th century, there has been a widespread shift in the causes of death and disability. In 1900, the major causes of death were infectious diseases such as pneumonia, tuberculosis, and diarrhea.[1] In contrast, in 1991, 73.8% of all deaths in Missouri were caused by four major chronic diseases: cardiovascular disease (i.e., heart disease and stroke), cancer, chronic lung diseases, and diabetes.[2] The burden of chronic diseases generates substantial health care expenditures and lost work productivity.[3]

Nationally, cardiovascular disease (CVD) claims nearly a million lives per year.[4] The yearly cost of CVD in the US is estimated at $101 billion.[4] In Missouri, a total of 22,371 CVD deaths were recorded in 1991.[2] This represented 44% of all deaths for that year. Recent studies reveal that much of the premature morbidity and mortality from CVD can be eliminated through risk factor reduction and early detection[4], and is therefore preventable. Although CVD has shown a decline in recent years, not all segments of the population are benefitting equally in these improvements in cardiovascular health.[5,6]

A large body of clinical and epidemiologic evidence has linked several risk factors with CVD. These include hypertension, cigarette smoking, physical inactivity, obesity, hypercholesterolemia, and diabetes.[3,7]

In this article, we report on regional and demographic differences for three CVD risk factors: high blood pressure, cigarette smoking, and physical inactivity. We used the Behavioral Risk Factor Surveillance System (BRFSS) to examine these three risk factors, which are among a group of risk factors targeted as priorities for the year 2000 at both state[8] and national[9] levels. Examination of the regional distribution of CVD risk factors provides the epidemiologic basis for developing prevention and control programs aimed at high risk areas of the state.

METHODS

The BRFSS was developed by the Centers for Disease Control and Prevention to assist state health departments in the measurement of modifiable risk factors. These risk factors include cigarette smoking, physical inactivity, obesity, hypertension, mammography utilization, and others.[10,11] Data on various behavioral risk factors are necessary to formulate and evaluate interventions, develop policy initiatives, and monitor the population's health behaviors over time.

The BRFSS uses a random digit dialing technique[10] to select adult Missourians ($\geq$18 years of age) for telephone interviews. The interviews are conducted monthly. Since Missouri began participation in the BRFSS, the yearly sample sizes have ranged from 882 in 1986 to 1,512 in 1992.

To examine regional differences in three cardiovascular risk factors (high blood pressure, cigarette smoking, and physical inactivity), we analyzed BRFSS data collected between the years 1986 and 1992. We chose these three variables for analysis because they are generally reported accurately in BRFSS-type surveys[12,13] and are public health priorities at state and national levels.[8,9] Standard BRFSS definitions were used.*

Data were analyzed according to the six state health districts. Sample sizes for each of six district were: Northeastern (n = 397), Southeastern (n = 816), South-

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*Definitions of risk factors used in BRFSS: high blood pressure: respondent has been told that blood pressure is high more than once or they are on hypertension medication; smoking: respondents reported currently smoking cigarettes; physically inactive: respondents reported fewer than three 20-minute sessions of leisure-time physical activity per week.

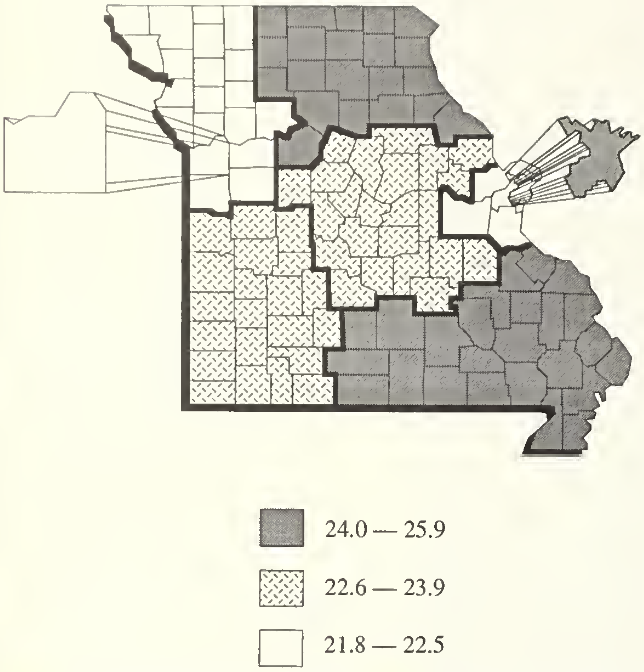

Figure 1. Prevalence (%) of high blood pressure among Missouri adults (1986-92) by health district.

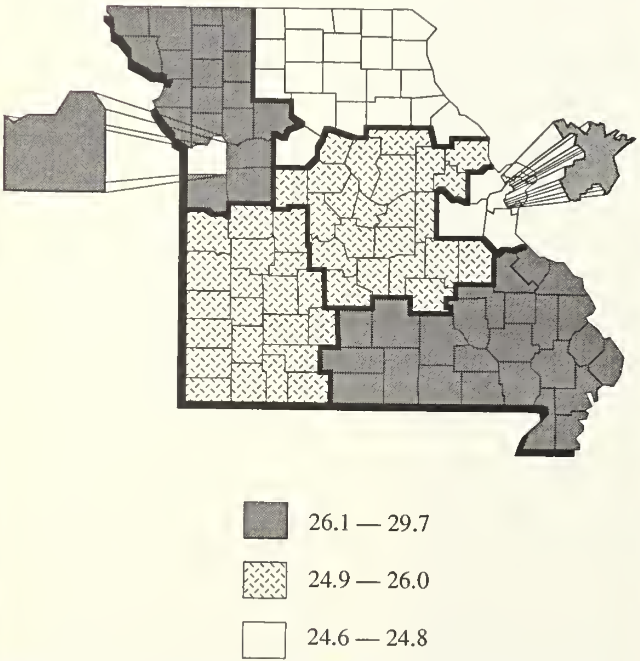

Figure 2. Prevalence (%) of cigarette smoking among Missouri adults (1986-92) by health district.

western (n = 1,019), Central (n = 1,030), Northwestern (n = 1,903), and Eastern (n = 2,916). In addition, sample sizes permitted separate analyses for St. Louis City and Jackson County (Kansas City).

Data were analyzed using the programs of SAS[14] and SUDAAN.[15] To further evaluate the regional differences of the three risk factor across the state, confidence intervals[15] were calculated to determine whether regional and demographic differences were statistically significant.

RESULTS

Figure 1 illustrates the prevalence rate of high blood pressure in the various geographical regions of the state. Hypertension prevalence rates varied from a high of 25.9% in Southeastern Missouri to a low of 21.8% in the Eastern District. The city of St. Louis had a self-reported hypertension rate of 25.6%. The prevalence of high blood pressure was significantly higher among Blacks (28.6%) than among Whites (22.9%).

Figure 2 shows the prevalence rates of cigarette smoking in the regions of Missouri. Smoking rates in these areas ranged from a low of 24.6% in Northeastern and Eastern Missouri, to a high of 27.8% in the Northwestern Health District. Jackson County also showed a high rate (29.7%) of cigarette smoking. BRFSS data showed that significantly more males (29.1%) smoke than females (24.0%).

Figure 3 illustrates the prevalence rates of physical inactivity throughout the health regions of Missouri. Physical inactivity rates varied from a low of 58.1% in Eastern Missouri to a high of 62.8% in Southeastern Missouri. The prevalence of physical inactivity was higher among Blacks (65.6%) than among Whites (60.0%). The highest physical inactivity rate of 69.3% was noted for Black females, and the lowest rate was 59.3% among White females.

DISCUSSION

While the current study examined regional differences in three CVD risk factors in this state, an earlier article provided data on regional variations in chronic disease mortality rates.[16] In these analyses, the cities of St. Louis and Kansas City and the Southeastern region of Missouri appear as the areas in most critical need of public health intervention.

A possible explanation for the clustering of high rates of CVD and its associated risk factors is that these areas have the highest percentage of African-American and economically disadvantaged populations in the state.[16] Numerous studies have demonstrated that mortality and/or morbidity from the targeted risk factors are higher among African-Americans than

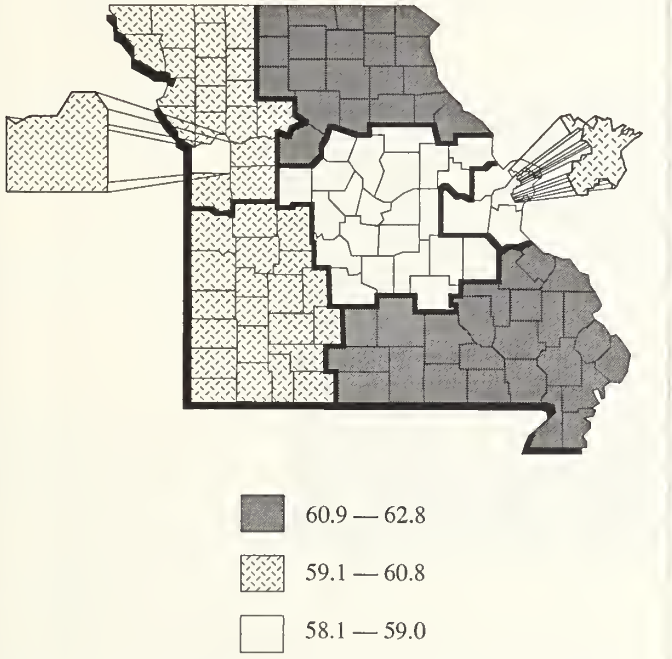

Figure 3. Prevalence (%) of physical inactivity among Missouri adults (1986-92) by health district.

among Whites.[5,6,9]

Although our data show elevated prevalence rates of CVD risk factors in various regions of Missouri, they also indicate tremendous potential for primary and secondary prevention activities.

Limited public health interventions are currently underway to address excess mortality due to these risk factors. Community-based coalitions are being developed and implemented in the metropolitan areas of St. Louis and Kansas City (**e.g.**, the Minority Cardiovascular Disease Prevention Task Force) and in the Southeastern region of the state (**e.g.**, the Bootheel Heart Health Project).[17,18] The major functions of these coalitions are to address the excess mortality/morbidity due to these risk factors and to reduce the risk of development of heart disease and stroke. The American Stop Smoking Intervention Study (Project ASSIST) is underway in Missouri to reduce the prevalence of smoking among high-risk populations.[19]

Physicians and other health-care providers can play an important role in reducing the prevalence of chronic disease risk factors. Clinicians have excellent opportunities for brief interventions. These include: 1) asking all patients about risk behaviors such as smoking, history of blood pressure, and physical inactivity; 2) giving specific recommendations on modifying high-risk behaviors; 3) assisting patients who want to make changes now; and 4) arranging follow-up visits. In the area of smoking cessation, for example, detailed advice is available in *How to Help Your Patients Stop Smoking: A National Cancer Institute Manual for Physicians* (can be obtained by calling the Cancer Information Service at 1-800-4-CANCER). The U.S. Preventive Services Task Force report: *Guide to Clinical Services* includes excellent summary chapters on exercise and nutrition counseling.[20]

With proper advice, support, and education, many patients can effectively manage diseases such as abnormal lipids, obesity, and hypertension without pharmacologic intervention. The recently released *Working Group Report on the Primary Prevention of Hypertension*[21] documents the efficacy of nonpharmacologic interventions (**i.e.**, weight control, reduced sodium intake, increased physical activity, and reduced alcohol intake) in reducing blood pressure and preventing the occurrence of hypertension. To overcome constraints on physician time and resources, patients can be referred to nurses, dieticians, health educators, exercise physiologists, and community programs for follow-up and education.

Recommendations for increasing physical activity were recently revised by the American College of Sports Medicine and the Centers for Disease Control and Prevention.[22] These revisions were based on a review of 43 studies and call for every American to accumulate 30 minutes or more of moderate-intensity physical activity over the course of most days of the week.[22]

Clearly, the CVD risk factors examined in this article have components that were not discussed (**e.g.**, socioeconomic conditions) and we cannot account for these factors in the types of analyses performed. It is evident that a complex array of issues such as labor, housing, access to health care, and social inequities all tribute to an individual's desire and ability to choose a healthier lifestyle.[23]

Our study is limited by the self-reported nature of the data collected through the BRFSS. Since the BRFSS relies on telephone interviews, it under-represents some high-risk populations who may have limited phone coverage, and therefore underestimates risk factor prevalence.[24]

Despite the difficulty in achieving long-term behavior change, a large preventive potential exists for eliminating the high prevalence rates of CVD risk factors in the state of Missouri.

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Dermatology Quiz #6

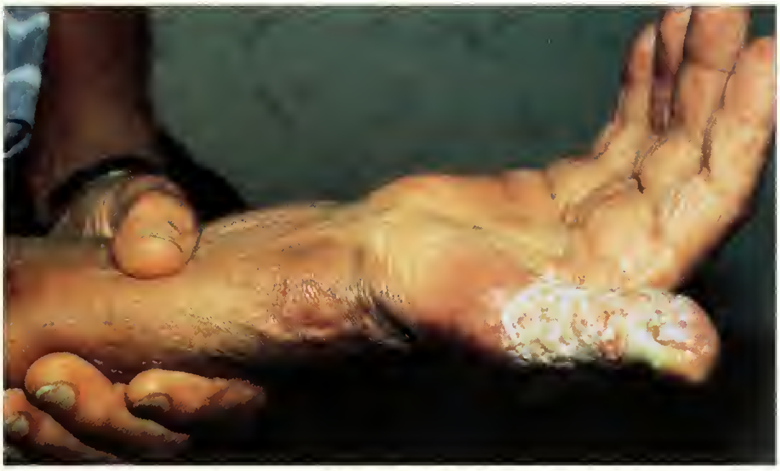

Figure 1

This 72-year-old gardener working with a bark and woodchip mulch mixture believed he "caught a splinter" in his finger that "festered up," but over six weeks, the problem grew unexpectedly much worse. Finally, of great concern to the patient, an ugly dark 1.5 cm nodule appeared on his arm. At first an ulcerated, mostly non-tender nodule developed on his finger, becoming slowly bigger, firmer and deep red in about 2 weeks. The patient tried to open the oozing nodule on his finger with a sewing needle to find the splinter, but he found nothing and the nodule then became much larger and more tender after the probing. He made his urgent appointment with the doctor when the new hard nodule arose near his wrist.

His physician found the firm necrotic chancriform nodule on the finger (figure 1) with a satellite nodule on the lymphatic chain, but he found no regional lymphadenopathy and no general illness or fever. The patient had no other new general symptoms or signs beyond his chronic obstructive pulmonary disease from a lifetime of infection, dust, and cigarette smoke.

1) The best one clinical diagnosis for this patient's chancre is:
   - a. Syphilis
   - b. Tuberculosis of the skin
   - c. Melanoma with metastasis
   - d. Cutaneous mycosis

2) The best next procedures prove the diagnosis is:
   - a. Biopsy
   - b. Culture
   - c. Syphilis serology
   - d. Tuberculin skin test

(*See Answer on next page.*)

DERMATOLOGY QUIZ ANSWER

(Dermatology Quiz Question is on previous page.)

Answer:

1) d. Cutaneous mycosis: Sporotrichosis

2) b. - with special instructions to the laboratory. Either a or b is likely to succeed, but b is more favorable.

Sporotrichosis is a very common seasonal disease of skin in the United States, particularly in agricultural regions where both humidity and summer temperatures are high. Missouri has a very suitable climate in June and July. The causative organism has been recovered reliably from decaying bark and wood, especially wood bits fragmented in dirt, but is not known to be a pathogen of plants. Farm horses can be infected and may pass the infection to handlers.

The disease sporotrichosis is caused by the common fungus, *Sporothrix schenckii.* Once inoculated into the skin, a chancre develops, and in 4-10 weeks nodules and tumors appear along the superficial lymphatics. Both culture and biopsy of sporotrichosis are definitive methods of proof, once the physician seizes on this diagnosis. Blind biopsy however is notoriously fallible because the fungus is not seen in the tissue without special stains or diastase treatment. Similarly, blind culture often will be reported "negative," and the fast growing pathogenic yeast will be dismissed as a contaminant, unless the clinician's presumption of sporotrichosis is made clear to the laboratory. The organism grows on Sabouraud agar at 20°C in about 3 days and can be identified positively. The more worrisome error on blind biopsy is to mistake the large pseudoepitheliomatous edge of the cutaneous chancre for squamous cell carcinoma.

Once the disease is familiar to the physician, the diagnosis of simple cutaneous sporotrichosis usually is made by eye. Some other considerations of chancriform lesions on hands might be mycobacteriosis, blastomycosis, bromoderma and syphilis.

Sporotrichosis is encountered all over the world, but especially in Mexico. A famous epidemic among gold miners in Africa is a classic report. One species of the fungus causes the disease everywhere. The disease is mostly among rural workers, although in large cities, flower-pot gardeners using sphagnum moss have been infected.

About 4/5 of all extra pulmonary sporotrichosis is the lymphocutaneous type as reviewed in the case of this patient. The incidence of silent pulmonary infection is not so clearly known, and may be important in the immunology of the disease. Although uncommon, sporotrichosis of the face and eyes is especially deceptive because the chancres ulcerate quickly, lymph nodes do not enlarge and on the ocular conjunctiva, the infection soon extends to involve the orbit.

Traditional treatment using a saturated solution of potassium iodide, 30 gtts TID, is usually successful (80% or so) especially when combined with local hyperthermia, however, the modern antifungal medications, for instance, itraconazole are much more elegant and, based on early results, even more effective. My top choice of treatment today would be itraconazole 200 mg qd for thirty days with regular assessment. It is typical that surgical probing, biopsies, or excisions, spread the infection. No debridement is needed; cures are usually prompt and uneventful. Very seldom does the cutaneous form of sporotrichosis disseminate, but bone lesions may occur locally. Pulmonary sporotrichosis is the principle risk after aspiration of the fungus. Infection from person-to-person is almost unknown.

Most older persons who develop sporotrichosis also have some associated illness that would impair their normal immunities. In this sense, sporotrichosis is sometimes termed "opportunistic." Clinical studies toward that concern are appropriate.

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Submitted and coordinated by Philip C. Anderson, MD, professor and director at the University of Missouri in the Division of Dermatology.

Special Series: Medical Informatics

Computer-assisted Instruction

John C. Reid, PhD

The rapidly growing number of medical subjects available on the computer is evidence of the popularity of computer-assisted instruction with students and teachers. Computerized education for medical students and teachers includes training on heart sounds, EKG interpretation, anatomical dissections, and a host of other topics. Many programs present "computerized patients," in which a medical student can work up a computerized case. On the computer, medical students can view a picture of the patient, histology slides and radiographs, can hear chest sounds, and can look up journal references or textbooks. The computer evaluates the medical student and at the end of the session and informs the student of good and also less auspicious decisions. The computerized patient costs less than real patients and requires little faculty time to evaluate the student's performance.

Students like the problem-solving format of computer-assisted instruction. They like to pursue questions that occur to them and to follow up ideas without embarrassing real patients. Students also comment that the computer lets them **see** patients having a wider variety of problems than they could at the clinic. With computer-assisted instruction their entire time is spent learning rather than waiting.

Technology enables a variety of resources to be attached to one computer. It is now commonplace for students to hear heart sounds, compare slides, look up definitions all in the same program. On the horizon we see *virtual reality* applications in which students wear a special helmet and put on special gloves that would let them **see** and **feel** a computerized patient in a physical examination.

At the University of Missouri, physicians and educators have designed several successful computerized applications for medicine.

A team lead by Alan J. Bridges, MD, now associate professor of medicine at the University of Wisconsin, and Joyce A. Mitchell, PHD, Director of the Medical Informatics Group at MU, wrote 35 computerized chapters to teach medical students and residents about rheumatology: rheumatoid arthritis, osteoarthritis and ankylosing spondylitis. This computerized system is called AI/LEARN/RHEUMATOLOGY. The program requires students to focus on key diagnostic features of diseases and to learn to discriminate between the concept being taught and other concepts. Screens have large type and are color coded so that students know where they are in a hypertext environment. Students can also request definitions and more information about a topic.

In a recently-concluded two-year experiment, Bridges and Mitchell found that students learned as much or more from the computerized instruction than from the traditional instruction, that students who used the computer more learned more, and that students rated the computer as the most helpful part of the block - even more helpful then seeing patients.[1] In one of the more interesting findings, students in the AI/LEARN/RHEUMATOLOGY group reported that they had seen more different diseases than students in the control group, even though a review of the number of consults showed that students in the treatment group actually had seen fewer consults than students in the control group. Apparently, students in the treatment group felt that the great number of examples presented by the computer more than compensated for the fewer number of real patients seen.

Students having no previous experience with a computer could use AI/LEARN/RHEUMATOLOGY with no more instruction than "move the mouse pointer to where you want it on the screen and click the mouse."

Marilyn Sanford, PhD and Director of Physical Therapy in Health Education at MU, revised these modules to be appropriate for physical therapy and occupational therapy students. In an extensive three-year study, Professor Sanford found that PT and OT students appreciated the computerized topics and that students in the computer group who worked with HP-RHEUM did better with the identification test of visual findings presented by slides than the control group.[2]

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Matthew Hile, PhD, and Marcie Descrochers, PhD, of the Missouri Institute of Mental Health, wrote a computer-assisted instruction program called SIDDS, to train clinicians how to assess and treat people with developmental disabilities.[3] It uses graphics and includes pre- and post-tests for self-assessments.

Laura Sievert, a third-year medical student at MU, wrote a Mac-based program in Supercard on interpreting magnetic resonance images of the ankle under the guidance of Alan Hillard, MD, assistant professor of radiology. Quiz items show a picture and students must choose one of several answers. Students can see other views of the ankle if they wish, and can click on "hint" if they are stumped. Students are enthusiastic about Sievert's program.

The new problem based curriculum which started this August at MU will rely heavily on computer-assisted instructions for independent learning and on other computer uses to find information.

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AIR FORCE

Let Us Now Revisit Prepaid Group Practice

Lawrence Kahn, MD

American medicine will soon enter health care reform. The Clinton Administration's Task Force on Health Care Reform is likely to introduce change that relies heavily on managed care, a field now dominated by the health insurance industry. Physicians can manage health care themselves by forming Prepaid Group Practices (PGPs). PGPs combine health insurance functions with physician managed health care. They can negotiate directly with health care purchasers, thereby abrogating the commercial health insurance industry.

Recently, two physicians talked about the practice of medicine. One was retired. The other was a young busy practitioner. The young physician said, "I know health care reform is coming. Medicine will change. I accept that. What I want to know is how can I keep on serving my patients, earn a living and support my family while the system changes? How do I get there from here?"

The Clinton Administration announced in May that the country can expect a proposal for health care reform in September. The content of that proposal has been subject to widespread prediction and speculation. Unless the Task Force on Health Care Reform has abandoned its charge, the recommendations will involve a fundamental change in the American health care system. It will begin in the health care marketplace. It will convert from one driven by its providers, i.e., physicians and hospitals, to one controlled by its purchasers, i.e., government and employers. "Managed Competition" is the current title applied to this conversion. Managed Competition will create huge groups of buyers called Health Insurance Purchasing Cooperatives or HIPCs. HIPCs will control the medical marketplace. Managed Competition will significantly affect American physicians. They can expect to practice medicine in an environment different from the one they know now. It will be more structured. It will include some governance of health care delivery beyond their own professional autonomy.

Thus, medical practitioners should explore new ways they can deliver care to their patients, preserve their profession, and secure their own future within health care reform. This commentary will describe one form of practice organization that fulfills those purposes. It is a physician collaborative for delivering health care. It follows closely the health delivery organization known as Prepaid Group Practice (PGP). With the arrival of health care reform, PGPs may well become more commonplace.[1]

Prepaid Group Practice is a system of health care delivery that undertakes the management and underwrites the financial risk for the comprehensive health care of the population it serves.

PGPs began in the early 1930s and were the models for the Federal Health Maintenance Organization (HMO) Act of 1973. Those Prepaid Group Practices remain not-for-profit organizations. Physicians work full time either as an independent group sub-contracting exclusively with the plan (group model) or as employees of the plan (staff model). PGPs are markedly different in operation and management from other versions of HMOs, specifically those organized as Independent Practice Associations (IPAs)[2] or Networks.[3] IPAs predominantly are commercial enterprises functioning essentially as health care insurers doing business at "arms-length" with physicians.

Nowadays, the ownership or sponsorship of Prepaid Group Practices includes commercial insurance companies, Blue Cross/Blue Shield, or independent entrepreneurs. There are also physician groups who own and operate PGPs alone or in affiliation with hospitals.[4,5]

Advantages and disadvantages exist in Prepaid Group Practice. Its most important value to physicians is that it enables them to preserve their professional autonomy. Its greatest disadvantage for physicians is the loss of some individual independence that now characterizes conventional medical practice in this country. It is the author's conviction that as the country enters health care reform, the medical profession will find the advantages of Prepaid Group Practice far outweigh its disadvantages. This is particularly the case for those prepaid group practices that physicians own and operate.

This argument for Prepaid Group Practice will include a description of its structure, its status within the health care system, and its governance. It will also describe the advantages and disadvantages for physicians and patients.

STRUCTURE

Prepaid Group Practice is a complete health care system in microcosm. As the health insurer for the population it serves, PGP markets the plan, underwrites the risk, collects and disburses revenue, and manages the information system. It combines its indemnifying function with its health delivery system through its physician group practice. The physician group is engaged full time in the practice. It provides comprehensive health care to the people who have enrolled in the plan. The physician group assumes the responsibility to do so within an acceptable, predetermined budget.

Revenues for PGPs are from prepaid, monthly premiums. Individuals enroll in groups under the sponsorship of an employer or other agency. Under health care reform, HIPCs would be the resource for patients and revenue. Enrollees or 'members' agree to the condition that the premium covers health care obtained only from the Prepaid Group Practice's physicians.

Saward eloquently described the characteristics of a PGP in 1968.[6] He described six components of PGPs he believed were essential for their survival. Those include: a physician group practice, prepayment for health services, capitation payment to the physician group (who convert the capitation to salaries), working in organized facilities with a central hub (typically, a medical center), voluntary enrollment of members, and comprehensive health coverage.

Status in the Health Care System

Prepaid Group Practices represent only 17 percent or 95 of the 556 operational HMOs in the United States. However, they deliver health care to 32 percent or 11.9 million of the 37.2 million HMO enrollees.[7] The 26 largest PGPs have a combined membership of 10.2 million. Twenty or 76.9 percent of these are not-for-profit. Nineteen of the 26 or 73.1 percent are group models. Several of these institutions are more than four or five decades old and serve populations ranging from several hundred thousand members to over two million.

Despite the success of established PGPs, new plans have not appeared in recent years. Almost all of these plans began before the current competitive managed care market began. Introducing a new PGP into a community with no involvement by the existing physician establishment is a difficult goal to achieve. There are high initial capital and fixed development costs. Much of the cost is in the recruitment and support of professional and ancillary staff and the establishment of facilities. In contrast, other forms of managed care, namely, IPAs and Preferred Provider Organizations (PPOs)[8], require comparatively little expense for their development. They integrate their new plan into the existing fee-for-service system in the community. There is no investment in patient care facilities. Their affiliated physicians provide those through their own capital investment. There is no fixed cost for professional services. Physicians receive compensation only after patients have enrolled in the plan and seek health care.

However, once established, Prepaid Group Practices hold a strong position in the health care marketplace. Their average premiums are lower than other forms of managed care. Staff and group model PGPs' premiums average 2.5 and 3 percent below those of IPAs that currently hold the largest segment of enrollment. Twenty-one of the 26 PGPs with more than 100,000 in enrollment reported a surplus/profit. The remaining five did not make that data available.

The cost of administration is another important factor. The price of administering commercial health insurance has become a central issue in the expenditures for American health care.[9,10,11] Administrative expense as a percentage of premium income varied widely by payer in 1990. It ranged from 2.1 percent for Medicare to 14.2 percent for commercial health insurance including indemnity coverage and managed care plans.[12] However, administration expenditures for PGPs are lower than for other forms of HMOs. An HMO industry survey showed that of 201 HMOs over three years old, the average administrative costs were 12.2 percent.[13] PGP's administrative costs were 11.9 and 11.0 percent for staff models and group models respectively. IPA and Network forms of HMOs had administrative costs of 12.7 and 11.8 percent respectively. These do not include profits or surpluses. Not-for-profit HMOs had administrative expenses of 10.6 percent while those of the for-profit HMOs were 13.3 percent. Not-for-profit PGPs represent 76 percent of all such plans and 90 percent of all PGP enrollees. While those differences may appear small, they amount to 10 to 15 percent lower costs for administration for not-for-profit PGPs, sizable amounts when translated into dollars.

What is more significant for physicians who affiliate with IPAs or PPOs is that this survey does not address private practitioners' office administration expenses. These are the costs for filing claims or obtaining approval for their decisions. Woolhandler and Himmelstein assessed the administrative costs per patient for practicing physicians. They found them to be at least equal to and possibly as much as double that of the insurance industry.[11] PGP physicians do not have those administrative burdens.

Claims processing and the process of validating eligibility, certifying appropriateness, and justifying payment is a major reason for the difference in administrative costs between PGP and other forms of managed care.[11] These activities with their attendant "hassle factor" are imbedded in IPAs and PPOs.

The typical activities of claims processing does not exist in PGP. As a self contained system in which salaried physicians deliver prepaid services, individual encounters require little or no financial exchange. Modest copayments at the time of service are the most frequent out-of-pocket expense for the enrollee.

Governance

A fundamental characteristic of PGPs is that physicians can participate effectively in the governance of the organization. Their involvement in the operation of the organization depends on their level of ownership and status of employment. Physicians who own the Prepaid Group Practice obviously control its governance entirely.

For physicians who are employees, the role in decision making exists but is less. Since they are employed full time and represent the essential professional resource delivering the services of the plan, their views and needs have weight.

The physician staff is headed by a Medical Director who establishes with them the rules of professional behavior. That includes deciding hours of appointment availability and the size and composition of the population each physician serves.

ADVANTAGES AND DISADVANTAGES FOR PHYSICIANS

The attributes of PGP that are of special relevance to physicians involve professional autonomy, physicians' compensation, and practice milieu. Comparing these aspects of PGPs to the other forms of managed care, namely, IPAs and PPOs shows their major advantages and disadvantages for physicians.

Autonomy

Physicians in Prepaid Group Practice retain their professional autonomy. They follow self-determined practice guidelines and policies for necessary and appropriate care. However, the dynamics of each patient-physician encounter are unrestricted by any specific external bureaucracy. Physicians in prepaid group practice exercise their professional judgment without pre-authorization.

This is in distinct contrast to other forms of managed care plans where practitioners' decisions are frequently subject to the plan's ratification. In those plans, the cost effectiveness of physicians is under continuous surveillance.

Physicians in PGP will retain professional autonomy, but they will have less personal independence. Belonging to a PGP requires giving up some personal freedom to conform to the rules of the organization. The group, not the individual physician, decides the scope of responsibility and the rules of the work place.

Physicians' Compensation

PGPs pay physicians by salary rather than by fee-for-service or direct capitation. Physicians evaluate the performance of their peers. The group decides each physician's salary. Many physicians accustomed to fee-for-service compensation often reject that approach. However, the involvement of the third party payer in their encounters with patients has made personal income by salary a more attractive alternative. Among methods of physician payment, fee-for-service is the one where dollars are most intrusive in the interaction between patient and physician. It is the system often used by IPAs and PPOs. The payer thrusts the dollar conspicuously into the transaction between physician and patient. Frequently, there are substantial financial penalties imposed on fee-for-service payment contingent on the physician's cost effectiveness.[14] It is pernicious. It casts a shadow on medical judgment.

Professional Milieu

In her description of the ideal health care system, Angell noted the importance of fostering "the morale of doctors and patients."[15] Should Managed Competition become a reality in health care reform, physician and patient morale will become an important issue.

Managed care plans of all kinds will compete to establish their place in American health care. Competition among them will be intense and that intensity in turn will convert to financial pressure on hospitals and physicians. Cost control is the essential function of managed competition. Physicians in Prepaid Group Practice will not be immune from the pressure to contain cost, avoid waste, exercise prudence. This will occur whether physicians are owners or employees. PGP provides an environment in which physicians and administrators have the opportunity to work cooperatively to accommodate to health care reform. Since both physicians and administrators are involved full time in their organization, they have parallel incentives for the PGP to succeed.

The reverse is the case for interaction between physicians and commercial health insurers or managed health care companies such as IPAs or PPOs. Physicians and administrators in IPAs and PPOs have a distant relationship with managers and different goals. Physicians may affiliate with several managed care companies. They have no special loyalty to any one company. Administrators of IPAs or PPOs deal with populations of physicians many times the size of those in PGPs. The company has a comparatively small investment in each physician. Individually, physicians are dispensable much more readily to the company than PGP physicians are to their Prepaid Group Practice. Competitive pressures on these managed care plans will shift to their physicians.

Still, the milieu of PGP has its hazards. The success of PGP depends on close collaboration among physicians and between the physician group and the administration. In that regard, it is important to note two recognized difficulties that can occur in PGP. These are disagreements that may occur between physicians and administrators and sometimes among physicians themselves. One has to do with how much work physicians should do for the salary they expect. The other has to do with how well PGP physicians respond to their patients.

Often, the discussion centers on what managers define as productivity and what practitioners consider to be patient responsibility. Physicians in private practice are familiar and comfortable with a specific fee for a circumscribed unit of service. Fee-for-service remuneration clearly defines practitioners' output and their resulting payment. Physicians in PGP are salaried. That method of remuneration is less measurable. Some salaried physicians are less motivated to see the same number of patients that they would see under fee-for-service compensation. They also seem to have less personal interaction with the patient.

PGP physicians may deliver care to the same number of patients as they would in a fee for service system and earn equivalent incomes. On the other hand, some physicians prefer PGP so as to practice in an unhurried style. They are willing to earn less in PGP than they might in private practice. They deny the lack of personal interaction. They consider measuring the number of visits per hour or per day as a poor index of their productivity.

PGPs attempt to establish rules of output for physicians. Some use strict guidelines such as the number of appointments per hour and the number of office hours per week. Other criteria are less rigid, measuring physician responsibility by the size of the population served with adjustment for age and morbidity. Whatever physicians and administrators adopt as an approach, it is important that a clear understanding exist as to the definition of the physicians' responsibility for patient care. Physicians' efforts must be cost effective; they must provide a volume of health services that justifies its revenue. Physicians must also respond to their patients' needs in ways that generate understanding and satisfaction. The physician group must assure the productivity and behavior of their group. Here is where individual independence gives way to the needs of the organization. When physicians do not define, recognize, and observe their responsibility, the results can be damaging.

ADVANTAGES AND DISADVANTAGES FOR PATIENTS

The main advantage for patients enrolled in PGPs is monetary. When premium costs and out-of-pocket expenditures combine with the range of benefits available, the cost of PGP typically is lower than any other form of health care. Copayments are the only out-of-pocket costs. Premiums for group and staff model prepaid group practices are lower than any other form of HMO.[5]

A major disadvantage is that the choice of physicians and hospitals includes only those associated with the plan. Other forms of managed care also limit choice, but the options are much broader. As noted, the panel of physicians in IPAs and PPOs is several times the size of one in a PGP. The difference becomes sharply focused when a patient in a PGP needs a subspecialty consultation for an unusual problem, and the consultant most highly regarded for that condition is not a member of the group. To respond to that limitation, some PGPs (and IPAs) offer an "open-ended" or "swing-out" option. This arrangement allows the patient to go outside the plan for health services but with that option is the responsibility for a substantial out-of-pocket cost.

Patients complain that they do not have continuous relationships with physicians. Further, the physicians seem uninterested in accommodating to patients' wants or needs. The incentive to "please the customer" and "service with a smile" generated by the fee-for-service system is a strong one. The connection between service and salary seems less apparent. The competitive environment of health care reform will change that.

Finally, patients may question whether health care is withheld for financial reasons. There is the risk in all forms of managed care that there might be an incentive to do less than is in the best interest of the patient.[17] In health care reform, the ideal would be to balance equitably the best interests of patients, physicians and the health plan. Managers believe this risk varies depending on the type of managed care.[18] In IPAs or PPOs, physicians' payment relates directly to the services they perform. Some IPAs withhold portions of physicians' compensation, the return of which is contingent on their cost effectiveness. Others use various levels of reimbursement depending on the cost-effectiveness of past performance.

In PGP the incentive to do less may also exist. Physicians are aware that their salary ultimately is a reflection of their professional actions. However, the gap between the specific actions of the physician and his or her remuneration is relatively wide when compared to other forms of managed care. The group evaluates the physician's overall value in deciding his or her salary. Within the operation of the group, there are quality assurance and general utilization revues that reveal differences in practice styles that also measure appropriateness. Physicians review physicians. Cost effectiveness alone is not the only issue. Hillman et al address approaches to preserving health care quality in the environment of cost containment in managed care.[19]

DISCUSSION

Health care reform in this country is now on a sustained course. Assuredly, cost constraint and managed care management will dominate the system. Health care reform may try to alter the role of indemnity health insurance, but the role of commercial health insurers in managed care is likely to increase.[20] Physicians have the alternative to take the responsibility themselves for managing and controlling the cost of health care.

Unfortunately, American physicians now are not in a good position to assume that responsibility. Physicians still try to function as individual entrepreneurs. More than half of all American physicians are in solo practice.[21] Three-fourths classify themselves either as self-employed or independent contractors. Slightly less than 10 percent are in groups of eight or more.[22] Fee-for-service payment still is the prevalent means of reimbursement. That fits poorly with the health care reform being fashioned by the Clinton Administration. Solo and small group practice are not positions of negotiating strength.

Physicians must look to different approaches to medical practice. PGP is a good one. The functional design of Prepaid Group Practice easily adapts to the new era of health care reform. It is a self-contained microcosmic system for delivering health care. It can receive compensation by capitation. The group can work under a fixed budget. PGP can preserve the important role of the physician in the health care system. It preserves professional autonomy while accepting the risk and responsibility for the cost of health care. PGPs can eliminate additional administrative costs by negotiating directly with the buyers of health care, the HIPCs. Since PGPs are in themselves health management organizations, they do not need an insurance company intermediary.

Clearly, introducing a new PGP remains difficult in the current health care marketplace. The inauguration of HMOs through federal funding, once available through the HMO Act of 1973, no longer exists. Within the new era of health care reform, legislators should consider federal financing to stimulate the formation of new PGPs. It would hasten the transition into the new era of American health care. It should be a serious consideration of the Task Force on Health Care Reform.

Even without major outside funding, organizing new PGPs are possible. They will be slower and more difficult to develop, but they can be organized. Many of the problems of instituting a new PGP in a community can be resolved if the established physicians there are the organizers. The first step would be the formation of Transitional Prepaid Group Practices.

Transitional PGPs can evolve as Prepaid Group Practices-Without-Walls. Physicians can continue to practice in their own facilities and maintain their affiliation with commercial HMOs and PPOs. Transitional PGPs must include two essential specific components. One is to negotiate as a group and seek capitation as revenue from the payer. The other is to pool revenue and compensate physicians by salary.

PGPs-Without-Walls require the adaptability of physicians established in practice who are willing to join in a large group organization. Physicians must develop a commitment to the concept of PGP and the patience to work through individual differences to create a unified organization. Large multispecialty group practices that have their own PGPs serve as examples. They hold enviable positions in their communities' health care system. Prepaid Group Practice works. Choices do exist.

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MAKING SENSE OF COAGULATION TESTS, A PRACTICAL APPROACH

David L. Pittman, MD and William B. Morgan, MT(ASCP)

A large variety of "clotting studies" are available to the clinician in evaluating the hemostatic capability of his patient. The authors have experience with these tests which are available in varying sophistication at hospitals ranging from 25-600 beds. In this article, the biochemistry and physiology of coagulation testing are purposely avoided. A common sense approach to evaluating the patient's "chance of bleeding or clotting" is presented.

Proper utilization of "clotting studies" and interpretation of these "coagulation tests" seems to be a challenge for old and new physicians, despite their training. Part of this stems from little emphasis on **coagulation medicine** in training, perhaps part of it from a lack of interest, and a significant part results from relatively unsophisticated tests available to monitor the "in vivo" hemostasis system. However, in their practices, the authors have defined certain repeated misinterpretations or misconceptions in coagulation testing. The purpose of this paper is to present a common sense approach to evaluate hemostasis, and discuss Basic, Intermediate, and High Level coagulation panels which can help physicians practicing at various hospital sizes and levels of care.

The Problem

To decide what tests are necessary, one must determine the **level of hemostasis** necessary for the procedure, therapy, or maintenance level required. For example for many Orthopedic Surgery procedures, 100% hemostasis is optimal during the procedure, but anticoagulation postoperatively is suggested to reduce the increased risk of thromboembolism. Some minor procedures require 100% hemostasis as well. A good example is the innocuous operative procedure of tonsillectomy and adenoidectomy. A raw surface is left unsutured, and bleeding will occur if the patient's hemostasis is impaired to even a mild degree (aspirin therapy). On the other hand, for most procedures where surgical hemostasis can be obtained (appendectomy, cholecystectomy, hysterectomy, bowel surgery), a patient with 30-50% coagulation factors does not generally bleed, and the physician should avoid giving unnecessary blood products to achieve a 100% level.

Hemostasis System

For practical purposes, coagulation testing evaluates five portions of Hemostasis. There are the Extrinsic system, Intrinsic System, Final Common Pathway, Fibrinolytic system, and Platelets. Important components of each system, and diseases or conditions which impair hemostasis by acting in this portion of the system are displayed in Table 1.

TABLE 1 Major Portions of Hemostasis Systems

PORTION OF SYSTEM	MAIN COMPONENTS	DISEASE STATES
Extrinsic	Liver dependent factors (2,7,10).	Warfarin Rx, liver disease, DIC, final common pathway diseases.
Intrinsic	Factors 5,8,9,11,12. Von Willebrand's (VW) factor. Antithrombin III.	Hemophilia A,B,C; VW disease, Heparin Rx, final common pathway diseases.
Final Common Pathway	Prothrombin, Fibrinogen.	Thrombolytic therapy, fibrinogen depletion (massive transfusion, long pump time coronary artery bypass, DIC.)
Fibrinolytic	Fibrinogen, plasmin, antithrombin 3.	Thrombolytic Rx, DIC, venomous snakebites.
Platelets	Platelet count, Plt aggregation studies, Bleeding time (BT).	ITP, TTP, DIC, Myeloprofilerative syndromes, hereditary platelet storage diseases.

At a small hospital where offering a large number of lab tests is not feasible due to cost, labor pool, or skills, a Basic Coagulation Panel containing the following tests should suffice.

Basic Coagulation Panel - Level 1 Tests

1. Protime (PT)
2. Activated partial thromboplastin time (APTT)
3. Platelet count
4. Template Bleeding time (BT)

These tests assess the basic components of the coagulation system as follows (Table 2).

An Intermediate Level Coagulation Laboratory (Level 2 tests) should offer the tests in the Basic Coagulation Panel (Table 2), as well as some of the reference tests listed in the footnotes of Table 2. (See Table 3)

Table 4 represents testing which might be available in a High Level Coagulation Laboratory (Level 3 tests). It includes all tests available in Tables 2 and 3 as well as those below.

TABLE 2 - BASIC COAGULATION PANEL

Test	Coagulation Pathway: Common Diseases States	Need Higher Level Test. Footnotes.
PT	Extrinsic System: Liver disease, Warfarin Rx, DIC[a], hypofibrinogenemia[b] (thrombolytic therapy).	a, b
PTT	Intrinsic system: Heparin Rx[c], Hemophilia A,B,C[d]; DIC[a], VW disease[e], hypofibrinogenemia (thrombolytic Rx)[b], inhibitors[f].	c, d, a, e, b, f
Platelet count	Platelet count: Thrombocytopenia such as - ITP[g], TTP[h], Marrow depletion such as - post-chemotherapy, drug incuded antibodies to platelets or HLA antibodies[i].	g, h, i
Bleeding Time	Platelet function, vascular integrity, and platelet count to lesser degree: Diseases leading to thrombocytopenia, vasculitis[j], myeloproliferative syndromes[k], hereditary platelet disorders[k], Drug Rx such as aspirin[k], VW ds.[e]	j, k, e

KEY TO FOOTNOTES:

a- Fibrin monomers or splits, Antithrombin III

b- Plasmin, fibrin splits

c- Thrombin time or Heparin absorbed assay (Hepasorb). +/- automated ACT.

d- Specific Factor Assays

e- Ristocetin platelet agglutination, Factor 8, VW factor (ristocetin cofactor), Multimers

f- Inhibitor screen, platelet neutralization procedure (PNP), Factor 8 inhibitor quantitation (Bethesda units).

g- Bone marrow examination, +/- platelet antibodies

h- Bone marrow examination, skin biopsy

i- Platelet drug antibody assay, HLA antibody screen

j- Skin biopsy

k- Platelet aggregation studies, bone marrow examination

DISCUSSION

These three Levels of Testing (Basic, Intermediate, and High Coagulation Panels) are not meant to be "set in stone" for each size of hospital, but are guidelines. At the authors' primary hospital, Table 4 lists reference tests with an asterisk(*). These tests are sent out due infrequent need, cost, and sometimes are of academic benefit only. Yet the authors believe their Coagulation Laboratory provides sufficient sophistication for this hospital which includes: a large cardiovascular program, an autologous bone marrow/stem cell transplant service as a part of a large oncology service, Obstetrics, and most other moderate-high intensity services or procedures offered.

Bleeding History

The importance of a bleeding history cannot be overemphasized! This is especially important in healthy patients scheduled for elective operations from approximately 10 to 50 years of age. These patients have adequate longevity to have had the hemostasis system challenged (injury, menses, teeth loss or extraction, other surgery, childbirth), yet are young enough to make acquired coagulopathies less likely.

Any patients with known serious illness (cancer, liver disease, kidney disease, vascular disease, autoimmune disease) should be considered to have a potential hemostasis defect, and should be tested with one of the panels prior to surgery. A suggested Bleeding History is as follows in Figure 1.

TABLE 3 - INTERMEDIATE LEVEL COAGULATION PANEL

PORTION OF SYSTEM	LEVEL 2 TEST	PURPOSE
Extrinsic	Mixing studies. Inhibitor screen.	Determine if prolonged PT, due factor inhibitor or deficiency.
Intrinsic	Mixing studies. Inhibitor screen.	As above.
Final Common Pathway	Thrombin time. Hebasorb or Automated ACT.	Determine if Heparin present.
Fibrinolytic	Fibrin monomers or splits. Antithrombin III. Fibrinogen.	Assess for DIC. Evaluate thrombolytic therapy.
Platelets	None	NA
Hypercoagulation	Fibrinogen, Antithrombin III.	Evaluate hypercoagulation.

TABLE 4 - HIGH LEVEL COAGULATION LABORATORY

PORTION OF SYSTEM	LEVEL 3 TEST	PURPOSE
Extrinsic	Specific Factor Levels	Determine deficient factor
Intrinsic	Specific Factor Levels PNP. Factor 8 inhibitor quantification.	Determine deficient factor. Lupus inhibitor. For Hemophilia A Rx.
Final Common Pathway	Immunologic fibrinogen.* Prothrombin level assay.*	Dysfibrinogenimia. Determine deficient factor.
Fibrinolytic	Plasmin.* Alpha$_2$ antiplasmin.*	DIC and fibrinolytic conditions.
Platelets	Platelet antibody screens,* HLA antibody screens,* Platelet drug/Antibody screens.	Determine if platelet antibodies present, and the type. Eg. - Heparin platelet antibody assay.
Hypercoagulation	Plasmin.* Alpha$_2$ antiplasmin.* Protein C.* Protein S.*	Evaluate in vitro hypercoagulability.

FIGURE 1 - BLEEDING HISTORY

Easy bruisability
Bleeding after dental extraction
Bleeding after surgery, requiring transfusion
Hemarthrosis
Severe menorrhagia
Recent ASA / Persantine ingestion
Liver disease, Hepatitis
Renal disease / dialysis
Low platelet count--ITP
Coumadin or Heparin therapy
Active autoimmune disease
Cancer
Family history of bleeding disorder

Common Problems or Misconceptions

Some common problems or misconceptions noted in the authors' experience at various hospitals over the years are as follows, **corrected** by the statements below.

1. Fresh frozen plasma is not the component of choice for every coagulopathy.
2. Recognize that Factor Assay levels are artifactually decreased by inhibitors.
3. Vitamin K will not normalize a Warfarin prolonged PT for 24 hrs. or more.
4. Tiny amounts of Heparin, as present in flushing central lines, can markedly increase the PTT. The Heparin level correlates with PTT in a semi-logarithmic relationship, unlike the more linear relationship of Heparin and the ACT.

5. The ACT is a poor test to determine if Heparin remains present, since the PTT is more sensitive. An example is in reversing the Heparin after CABG surgery.
6. Most minor elevations of the PTT (<10 seconds) in elective preoperative patients represent in significant in vitro inhibitors (often of lupus type), not a Factor deficiency.
7. Most patients with lupus inhibitors/anticoagulants do not have Systemic Lupus Erythematosus.
8. When both the PT & PTT are elevated, one should check the fibrinogen level. If it is less than 100 - 150 mg/dl, it may be responsible for the elevation (final common pathway) and may require cryoprecipitate infusion to correct associated bleeding.
9. Do not consider a low level of Fibrin monomers or splits to represent DIC in 1-4 days postoperative patients.
10. Antithrombin III (to a lesser degree platelet count and fibrinogen) are better DIC monitoring tests on a day to day basis, than the more acutely reacting fibrin monomers or splits.
11. Some people consider Coagulation Medicine to be quite sophisticated, and a given in vitro test to correlate perfectly with the patient's chance of bleeding or clotting. Unfortunately, we have a long way to go. Our tests to evaluate for **Hemorrhage** are imperfect, but have at least one level of predictive value/utility over our basic tests to evaluate for **Hypercoagulation**.
12. Operative patients with an extrinsic or intrinsic system defect usually do not bleed for 2-6 hours postoperatively since the primary clot is a platelet fibin plug, which can be formed normally.
13. Mildly elevated Protime and aPTT are sometimes spurious due to:
    - A. Inadequate venipuncture with excess citrate anticoagulant per sample.
    - B. Traumatic draw or poor line draw technique, causing partial activation of the clotting or fibrinolytic cascade.
    - C. High hematocrit, resulting in excess citrate/plasma ratio.
14. A repeat venipuncture sample is always recommended prior to clinical action on an abnormal coagulation result which does not correlate with the clinical setting.

Standard Interpretive Comments

One of the authors (DLP) has recently instituted standard pathology **interpretive comments** to aid in the understanding of coagulation tests, and to recommend appropriate further testing for some of these abnormal values (Figure 2).

FIGURE 2 - INTERPRETIVE COAGULATION COMMENTS

1. **DIC Screen**
   - A. No definite lab evidence of DIC.
   - B. Intermediate pattern suspicious for low grade, early, chronic DIC; or postoperative state.
   - C. Positive lab screen for DIC.
2. **Heparin Platelet Antibody Screen**
   - A. Thrombocytopenia with negative Heparin Platelet Antibody Screen.
   - B. Thrombocytopenia with borderline Heparin Platelet Antibody Screen, suggest repeat in 24 hr. if clinically desirable.
   - C. Thrombocytopenia with positive Heparin Platelet Antibody Screen, suggests Heparin Induced Thrombocytopenia.
   - D. Negative Heparin Platelet Antibody Screen.
   - E. Borderline Heparin Platelet Antibody Screen, repeat in 24 hr. if clinically indicated.
   - F. Positive Heparin Platelet Antibody Screen.
3. **Isolated Prolonged APTT**
   - A. Prolonged APTT with + HepSorb, suggest Heparin effect.
   - B. Prolonged aPTT with normal plasma correction, suggests intrinsic factor deficiency, Heparin, or thrombolytic agent.
   - C. Prolonged APTT without normal plasma correction, recommend inhibitor screen.
   - D. Prolonged aPTT, suggests Heparin effect, factor deficiency, or thrombolytic agent.
4. **Isolated Prolonged Protime (PT)**
   - A. Prolonged PT, corrects with normal plasma, suggests Factor deficiency, Coumadin, or thrombolytic agent.
   - B. Prolonged PT without normal plasma correction, recommend inhibitor screen.
5. **Prolonged PT & aPTT**
   - A. Prolonged PT & aPTT, recommend fibrinogen level & DIC screen.
   - B. Prolonged PT & aPTT, with decreased fibrinogen or platelet count, recommend DIC screen.
6. **Significant Prolonged Bleeding Time (over 15 min.)**
   - A. Bleeding Time over 15 min, recommend platelet count.
   - B. Bleeding Time over 15 min, normal platelet count, suggest platelet aggregation studies if vascular integrity normal.

FIGURE 3 - INTERPRETIVE TRANSFUSION THERAPY COMMENTS

A. Given the laboratory data and clinical status, I would recommend 10 or more units of cryoprecipitate in an attempt to raise the fibrinogen level to 150 or greater and achieve hemostasis control. I recommend monitoring the coagulation status (PT, PTT, fibrinogen, & platelet count) 30 minutes after the cryo. is transfused.

B. Given the laboratory data and clinical status, I would recommend 2 or more units of FFP in an attempt to reduce the protime (PT) and achieve hemostasis control. I recommend repeating the PT 30 minutes post transfusion.

C. Given the laboratory data and clinical status, I would recommend 2 or more units of FFP in an attempt to reduce the aPTT and achieve hemostasis control. I recommend repeating the APTT 30 minutes post transfusion.

D. Given the laboratory data and clinical status, I would recommend a pheresis platelet pack in an attempt to increase the platelet count and achieve hemostasis control. I recommend repeating the platelet count 30 minutes post transfusion.

E. I recommend DDAVP (desmopressin) dosage in an attempt to achieve hemostasis control by increasing Von Willebrand's factor activity and platelet function.

F. I recommend Protamine dosage in an attempt to reverse the Heparin effect on hemostasis, if clinically indicated.

Similarly, this author's standard **transfusion therapy comments** are listed in Figure 3. These Interpretive Comments are intended to provide timely consultation when an abnormal coagulation result or panel is found.

CONCLUSION

This article is intended to aid medical students and physicians in their understanding and interpretation of coagulation testing, with application to disease diagnosis and treatment.

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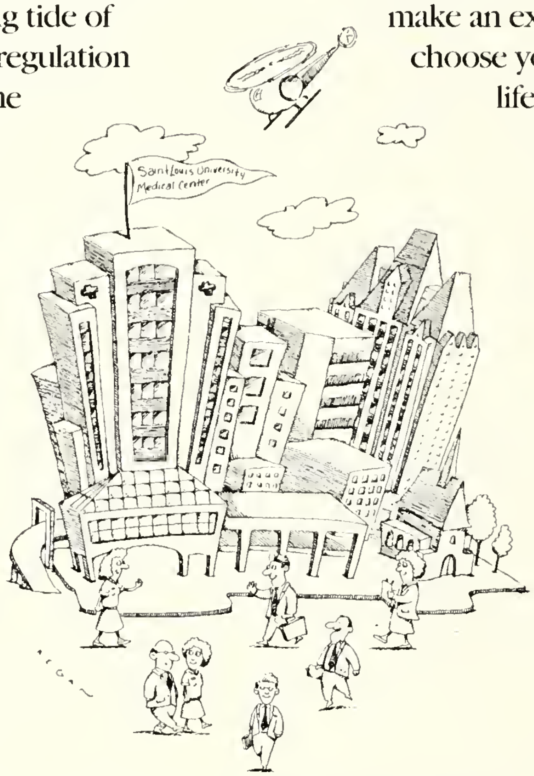
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AN ADULT CASE OF ACUTE BIPHENOTYPIC LEUKEMIA WITH CHARACTERISTIC MIXED MORPHOLOGY

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A case of acute biphenotypic leukemia with mixed blast morphology and combined myeloid and T-lymphoid features is reported. The leukemic cells consisted of small lymphoid hand-mirror blasts and large blasts with cytoplasmic granules and rare Auer rods. The cells expressed myeloid and immature T-lymphoid features by cytochemistry and immunophenotyping, however T cell receptor genes were in germline configuration. Cases of biphenotypic leukemia with similar morphological and immunophenotypic findings have been described previously in children. This case represents a morphologically and phenotypically distinct subtype of acute biphenotypic leukemia.

With the recent widespread application of immunophenotypic and gene rearrangement studies, it is now recognised that a significant proportion of cases of acute leukemia are of mixed lineage, expressing both myeloid and lymphoid characteristics.[1-10] When more than 10% of the malignant cells express both lymphoid and myeloid features, the leukemia has been termed biphenotypic, as opposed to bilineal, where two distinct cell populations are present.[3] In most reports of mixed lineage acute leukemia in adults and children, blast morphology and cytochemistry has been consistent with one of the French-American-British (FAB) categories, despite considerable immunophenotypic and/or genotypic heterogeneity.[4,8,11-13] A morphologically and clinically distinct subtype of acute biphenotypic leukemia with combined myeloid and T-lymphoid features has been described in children, characterised by dimorphic blast morphology.[1,10,14] We report here a case of acute biphenotypic leukemia in an adult, which appears to fit into this unique category.

CASE REPORT

A 40 year old man was admitted to another hospital with pneumonia and found to have an abnormal blood count. He was treated with antibiotics and transfused with two units of blood. Two weeks later he presented with a two month history of fatigue, weight loss, recurrent fever and night sweats. Physical examination revealed nontender enlargement of cervical, axillary and inguinal lymph nodes. There was no enlargement of liver or spleen. The hemoglobin was 8.6g/dL, platelet count 138 x 10^9/L, and white blood cell count 22.7 x 10^9/L with a differential count of 8% segmented neutrophils, 1% bands, 1% myelocytes, 9% lymphocytes, 4% monocytes, 9% eosinophils, 23% atypical lymphoid cells and 45% blasts. A peripheral blood sample immunophenotyped by flow cytometry was found to be consistent with T-cell acute lymphoblastic leukemia (T-ALL). Chest X-ray showed no evidence of mediastinal widening. A bone marrow aspirate and biopsy were submitted one week later for morphological evaluation, cytochemistry and immunophenotyping by flow cytometry, and the findings were reported as consistent with acute biphenotypic leukemia.

The patient was treated with an adult acute lymphoblastic leukemia (ALL) induction protocol consisting of a five week course of vincristine (2mg/M^2), prednisone (60mg/M^2), adriamycin (20-30mg/M^2), intrathecal methotrexate (6mg/M^2), and cyclophosphamide (600mg/M^2). He attained complete remisson, received consolidation therapy, and is currently in remission on a maintenance protocol, one year following his initial diagnosis.

MATERIALS AND METHODS

Light microscopic examination and cytochemistry

Peripheral blood and bone marrow aspirate smears were stained with Wright's stain (Curtin Matheson Scientific, Houston, TX). Cytochemical stains performed on bone marrow aspirate smears included Sudan black B, chloroacetate esterase, alpha-naphthyl butyrate esterase, acid phosphatase, and periodic acid-Schiff stain (Sigma Diagnostics, St. Louis, MO). Myeloperoxidase stain was performed by an outside laboratory (positive staining in more than 3% of blasts was considered a positive reaction). A bone marrow biopsy was fixed in B5 fixative, rapidly decalcified in hydrochloric acid/EDTA, and embedded in paraffin. Sections were stained with hematoxylin and eosin.

Terminal deoxynucleotidyl transferase (TdT) analysis

An immunocytochemical stain for nuclear TdT was performed on bone marrow aspirate smears fixed in acetone/methanol for 60-90 seconds, using a primary mouse monoclonal antibody against TdT (Dakopatts, Glostrup, Denmark), and an alkaline phosphatase-labelled streptavidin-biotin technique (Dako Quick Staining Kit, Dako Corp., Carpenteria, CA). Nuclear staining of 5% or more blast cells was considered positive.

Immunophenotyping

White blood cells in peripheral blood and bone marrow were analyzed immunophenotypically by dual color flow cytometry, using monoclonal antibodies labeled with either fluorescein (FITC) or phycoerythrin (PE) and specific for CD2, CD3, CD4, CD7, CD8, CD13, CD14, CD19, CD20 and HLA-DR (Coulter Corporation, Hialeah, FL), and CD5 (Gen-Trak, Inc, Plymouth Meeting, PA). Aliquots of whole blood or bone marrow were incubated with antisera, then treated to lyse red blood cells and stabilize cell membranes (Q-Prep, Coulter Corporation, Hialeah, FL). Cell preparations were analyzed on a Coulter EPICS Profile flow cytometer (Coulter Corporation, Hialeah, FL).

Gene rearrangement studies

Leukemic cells from peripheral blood and bone marrow were analyzed for T and B cell gene rearrangements by Southern blot. DNA extracted from leukemic cells was digested with Bam HI, Eco RI, and Hind III restriction enzymes (Oncor, Inc, Gaithersburg, MD). DNA fragments were electrophoresed in agarose gels and transferred onto nylon membranes using a Probe Tech 2 instrument (Oncor, Inc, Gaithersburg, MD). Gene rearrangements were detected with biotin labeled probes specific for the T cell receptor beta chain (J I/J II) and gamma chain (J),and B cell immunoglobulin heavy (J_H) chain (Oncor, Inc, Gaithersburg, MD).

Cytogenetic analysis

Cell suspensions from bone marrow were processed by culture for both 24 and 48 hours; 24 hour cultures were treated with Colcemid both overnight and for 30 minutes. The samples were analysed by Giemsa trypsin banding.

RESULTS

Morphology and cytochemistry

Examination of peripheral blood showed the presence of many small lymphoid-appearing blasts with a high nuclear-cytoplasmic ratio and inconspicuous nucleoli, and occasional larger blasts with a greater amount of cytoplasm and prominent nucleoli. In the bone marrow, a mixture of blast cells was even more prominent (Fig. 1). Small lymphoid-appearing blasts comprised 50% of nucleated cells, many displaying a hand-mirror configuration and cytoplasmic vacuoles. Larger blasts comprised an additional 20% of nucleated cells, some containing cytoplasmic granules. Rare Auer rods were noted in the larger cells. The marrow biopsy was hypercellular with normal hematopoietic elements replaced by sheets of blasts, most of which were small, with an admixture of larger cells.

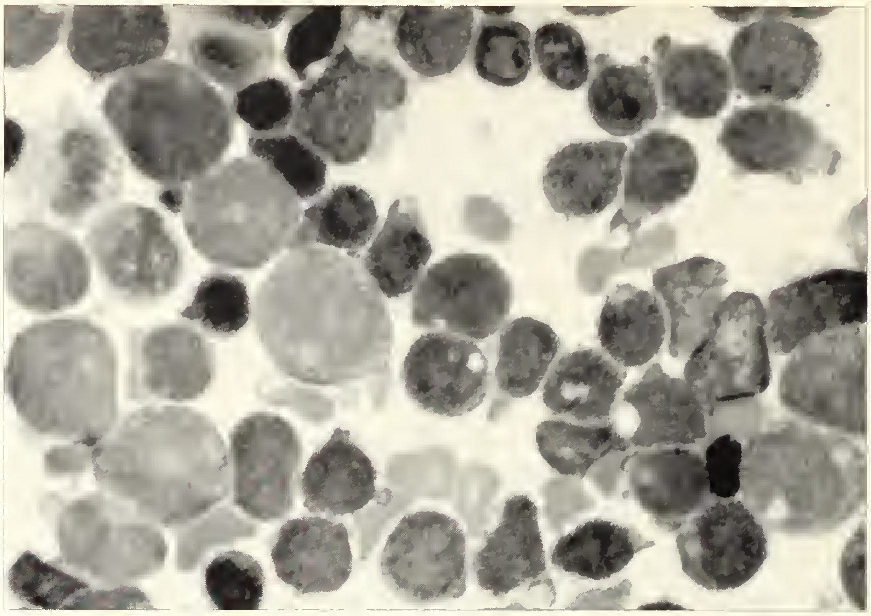

FIG 1. Bone marrow aspirate showing mixture of small lymphoid blasts, some with hand-mirror configuration, and larger blasts with prominent nucleoli. Wright's stain (magnification, x1000)

Sudan black B and chloroacetate esterase stains showed positive-staining granules in 20-25% of blast cells. The positive-staining cells were predominantly, but not exclusively, the larger blasts. Myeloperoxidase stain was also positive. Alpha-naphthyl butyrate esterase and periodic acid-Schiff stains were negative. Acid phosphatase stain showed a focal positive staining pattern in 15% of blasts, predominantly the smaller cells.

Immunologic studies

Immunocytochemical stain for TdT was positive in both peripheral blood and bone marrow, with positive nuclear staining in 20% and 15% of the blasts respectively. The positive-staining blasts included both small and larger forms.

Flow cytometric immunophenotyping was performed on peripheral blood and bone marrow (Table 1). The gated population included predominantly smaller leukemic cells. In the peripheral blood, the leukemic cell population was positive for CD2, CD7 and HLA-DR, and negative for CD4, CD8, CD5 and surface CD3. This pattern resembled

TABLE 1
IMMUNOPHENOTYPIC PATTERN OF LEUKEMIC CELLS

Antigen		Percent positivity	
		Peripheral blood	Bone marrow
B Lymphoid	CD19	3	0
	CD20	2	ND
T Lymphoid	CD2	88	94
	CD3	19	4
	CD4	7	ND
	CD5	12	ND
	CD7	74	66
	CD8	7	ND
Myeloid	CD13	17	26
	CD14	14	ND
Other	HLA-DR	40	30
	CD7+CD13	ND	12

ND: not done

the phenotype of prothymocytes, consistent with immature T-ALL. The myeloid marker CD13 was considered negative. Immunophenotyping of bone marrow (Table 1) also showed the presence of immature T-cell markers, however a significant proportion of cells was positive for the myeloid marker CD13. By simple addition of cells positive for CD2 (94%) and CD13 (26%), it was evident that some cells carried both T cell and myeloid markers. This was confirmed by subsequent flow cytometric analysis of bone marrow using CD7 and CD13 as a dual color reagent. While a large proportion of cells expressed CD7 only, 12% of cells expressed both CD7 and CD13.

Gene rearrangement studies

No clonal rearrangements of the T cell receptor beta chain gene, T cell receptor gamma chain gene, or immunoglobulin heavy chain gene were detected.

Cytogenetic analysis

Chromosomal analysis of the bone marrow revealed an abnormal clone with a complex translocation involving chromosomes 13, 20, and 22, and a paracentric inversion of chromosome 3 [46,xy,inv(3)(q21q26), t(13;20;22)(p11;q11;q11) or t(13;20;22)(q11;q11;p11)].

DISCUSSION

Recently, it has been stressed that stringent criteria should be required for the diagnosis of biphenotypic leukemia, since isolated morphological, cytochemical or immunophenotypic features do not necessarily indicate lineage involvement.[3] The case we have described fulfills these recommended criteria, with adequate evidence of involvement of myeloid lineage (CD13 expression, Sudan black B and myeloperoxidase positivity, and presence of Auer rods) and T lymphoid lineage (CD2 and CD7 expression, TdT and focal acid phosphatase positivity). Furthermore, more than 10% of malignant cells were shown to coexpress myeloid and lymphoid antigens by two color flow cytometric analysis, complying with the definition of biphenotypic rather than bilineal leukemia.[3]

In most reports of mixed lineage acute leukemia in children and adults, cases have been classified into one of two groups - acute lymphoblastic leukemia (ALL) with myeloid features, or acute myeloid leukemia (AML) with lymphoid features, with the primary designation based on FAB criteria.[4,6-8,11-13,15,16] Blast morphology and cytochemistry in these cases have generally been consistent with one of the FAB categories, although unusual morphological features, such as lymphoid blasts with azurophilic granules[16], and unusual cytochemical reactions[7,16] have been described.

The case presented here closely resembles a unique subtype of acute biphenotypic leukemia previously described in children, with combined features of AML and T-ALL, and characterised by a mixture of large and small blasts.[1,10,14] Our patient demonstrated the morphological features described in these cases - small lymphoid-appearing blasts, in some cases with a hand-mirror configuration, and larger blasts that were myeloid in appearance with more abundant cytoplasm, granules and rare Auer rods. The previously described patients were all younger than 20 years; our patient appears to represent the first reported case of the same disorder in an adult. Other cases of biphenotypic AML/T-ALL reported in adults[8,12,16] have lacked the characteristic mixed morphology described above.

The childhood cases referred to above were classified primarily as AML (with lymphoid features), since, as in our case, myeloperoxidase and Sudan black B were positive in more than 3% of blasts. Because these cases display a truly mixed morphological, cytochemical and immunophenotypic picture, it is difficult to assign dominance to any one lineage, and it may be preferable to classify them in a separate category.[5]

Neither T cell receptor beta chain genes nor gamma chain genes were clonally rearranged in this case, possibly related to the very immature prothymocytic phenotype. There is evidence that T cell receptor beta and gamma chain genes are rearranged in the early stages of thymocyte differentiation, the genes still being in germline configuration in the prothymocyte stage.[19] The absence of T cell receptor beta or gamma chain gene rearrangement may also indicate aberrant T cell differentiation, not representative of normal hematopoiesis.

Cytogenetic analysis in this case showed a complex translocation involving chromosomes 13, 20 and 22. The breakpoint in chromosome 22 was thought to possibly represent the same band as that involved in the standard Ph chromosome [t(9;22)(q34;q11)], however molecular bcr analysis would have been required to further investigate this. No consistent chromosomal abnormalities were reported in similar childhood cases, apart from translocations involving 14q32 in one of the reports.[10]

Children with T-ALL/AML were reported to have a poorer response to remission induction therapy than those with typical AML[14], although event-free survival did not differ between the two groups.[10] Furthermore, several children in this group failed induction chemotherapy on AML protocols, and subsequently responded to ALL-directed therapy.[1,10,14] In adults with AML, expression of lymphoid antigens has been associated with an improved survival.[12] The patient presented here was initially treated with an aggressive adult ALL protocol - he achieved complete remission, and is well after one year of follow-up.

In summary, this case of biphenotypic T-ALL/AML with characteristic mixed morphology in an adult is similar to childhood cases reported previously, and appears to represent a morphologically, immunologically and clinically distinct form of mixed lineage leukemia.

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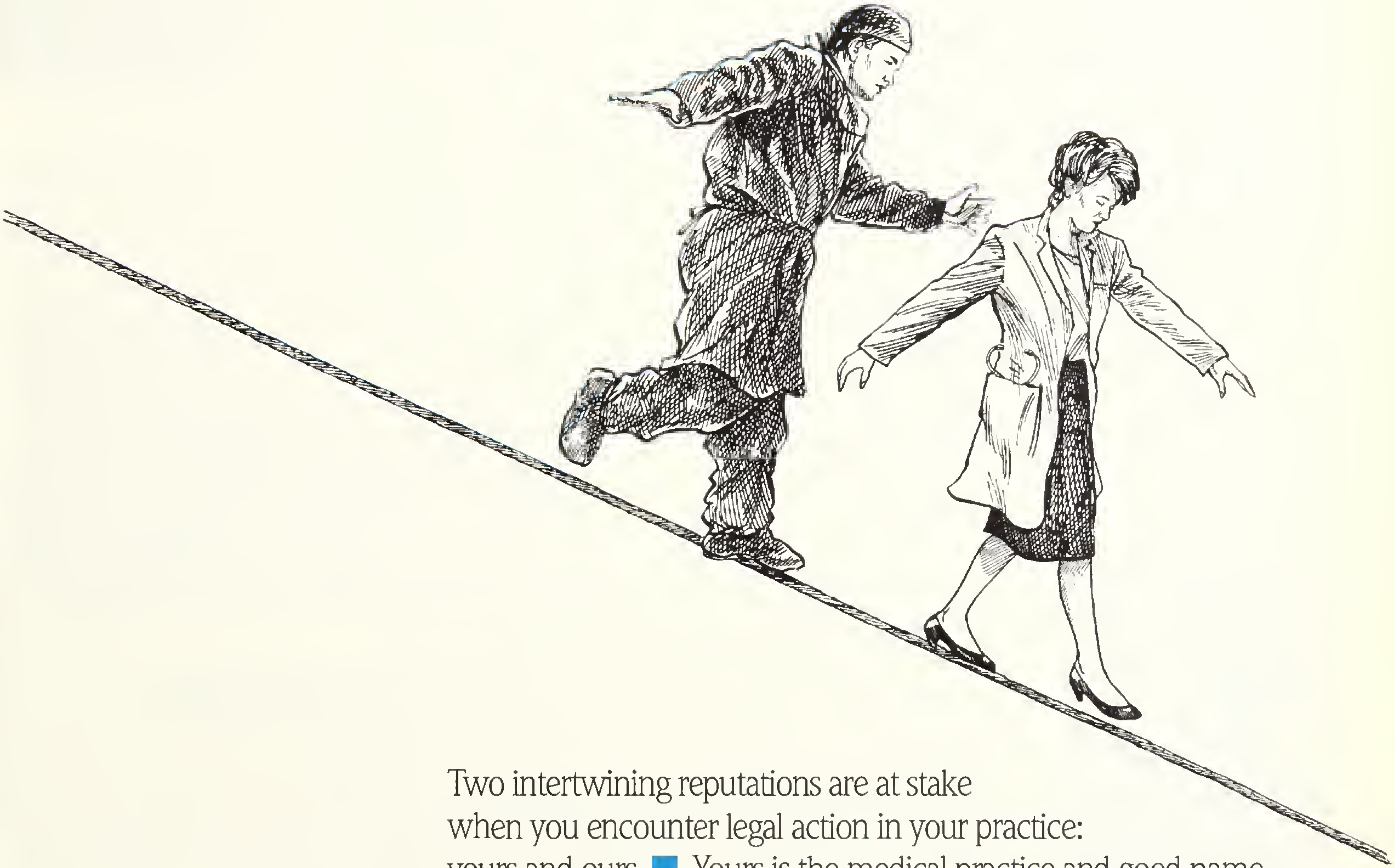

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University of Missouri - Columbia

John W. Cowden, MD

John Williams Cowden, MD, has been named chairman of the MU department of ophthalmology. Dr. Cowden was professor and co-chairman of ophthalmology at Wayne State University's Kresge Eye Institute in Detroit. He will hold the Roy E. Mason Distinguished Professorship in Ophthalmology and also will direct MU's Mason Institute in Ophthalmology. Dr. Cowden is currently president of the Michigan Ophthalmological Society and serves on the medical advisory board of the Eye Bank Association of America. A 20-year member of the board of directors for the Michigan Eye Bank and Transplantation Center, he has developed several innovations in corneal transplantation. In the late 1970s and early 1980s, he and other Wayne State researchers pioneered radial keratotomy.

David Ota, MD

David M. Ota, MD, has been named medical director of MU's Ellis Fischel Cancer Center. He comes from the University of Texas M.D. Anderson Cancer Center in Houston, where he served on the surgery faculty since 1980.

Susan H. Allen, MD, PhD, assistant professor of internal medicine, has been awarded funds from the U.S. Department of Education's National Institute of Disability and Rehabilitation Research for three-year study of conditioning exercise and osteoporosis in women with rheumatoid arthritis.

Charles L. Puckett, MD, professor and chief of plastic surgery, was installed as chairman of the American Board of Plastic Surgery.

Henry Stonnington, MD, professor and chairman of physical medicine and rehabilitation, was elected president of the Central Society of Physical Medicine and Rehabilitation. He also was elected to the Board of Governors of the American Congress of Rehabilitation Medicine for the second year.

A 12-year study of diabetic eye disease at the University of Missouri-Columbia reports that families and physicians should try to keep the blood sugar levels of diabetic children under strict control following diagnosis of the disease. The findings dispel a popular view that diabetes causes no damage in the body before puberty because eye, nerve and kidney complications do not become evident until the teen years. Missouri research included 420 male and female children and teens with Type I diabetes. Most of the subjects entered the study shortly after being diagnosed and showed no early signs of retinopathy. Researchers compared disease progression to how well patients controlled their glucose level. Children whose blood glucose levels were maintained close to those of non-diabetics through insulin shots and diet were much less likely than subjects with poor glucose control to develop serious eye problems.

George Cicila, PhD, research assistant professor of internal medicine, has identified the first genetic mutation linking excess dietary salt to high blood pressure. Other hypertension researchers have pinpointed loci in which genetic defects are found but never linked a specific mutant protein to blood pressure regulation. The studies were conducted on salt-sensitive and salt-resistant rats. Dr. Cicila plans to test the hypothesis that a similar mutation may be present in salt-sensitive humans.

St. Louis University

The name St. Louis University Medical Center has been changed to St. Louis University Health Sciences Center. The new name is to more accurately reflect the academic and community services which the center provides. St. Louis University Medical Center includes a hospital, outpatient care, schools of medicine, nursing, allied health professions and the only school of public health in Missouri.

Kenneth R. Smith, Jr., MD, professor of surgery and director of the division of neurosurgery was elected vice president of the Society of Neurological Surgeons. Dr. Smith will serve on the society's executive council and will work with various committees to help govern the organization and plan programs.

Richard S. Kurz, PhD, has been named dean of the St. Louis University School of Public Health. Dr. Kurz was the associate dean of the school since its establishment in May 1991. He assumes the position held by **James R. Kimmy, MD, MPH,** who recently was appointed vice president for health sciences and

James R. Kimmey, MD

chief executive officer for St. Louis University Health Sciences Center. Dr. Kimmey joined the university's staff in 1978 as director of its academic programs in health administration, public health and health services research.

Donald P. Hay, MD, has been appointed associate professor of psychiatry and human behavior and director of the division of geriatric psychiatry inpatient program. Dr. Hay was an associate professor and director of the division of geriatric psychiatry at the Medical College of Wisconsin, associate clinical professor of psychiatry at the University of Wisconsin Medical School-Milwaukee Clinical Campus, and the director of both the geriatric psychiatry program and the electroconvulsive therapy program at St. Mary's Hill Hospital.

Joseph J. Baldassare, PhD, associate professor of internal medicine in the division of nephrology, has received a two-year grant from the American Heart Association to study the enzymes responsible for stimulating platelet.

William S. Sly, MD, professor and chairman of the department of biochemistry and molecular biology, has been awarded a five-year grant from the National Institute of General Medical Sciences to continue enzyme research. The funds will be used for a project called "Receptor Mediated Transport of Lysosomal Enzymes." A shortage of lysosome enzymes that leads to diseases such as Tay Sachs or Gaucher.

Jung San Huang, PhD, professor in the department of biochemistry and molecular biology, received a five-year grant from the United States Department of Health and Human Services in support of cancer research. The funds will be used for a project called "Roles of Polypeptide Growth Factors in Cell Growth." The program looks at the molecular mechanisms of normal cell and cancer cell growth in the body.

Maw-Shung Liu, DDS, PhD, professor in the department of pharmacological and physiological science received a five-year grant from NIH to continue his studies on how bacterial-induced shock promotes heart failure.

The Eye Institute at St. Louis University Health Sciences Center opened in July. It moved from its quarters in Bethesda General Hospital to redesigned building at 1755 S. Grand Blvd. in the old Missouri Pacific Hospital (CareUnit Hospital).

The Eye Institute has received FDA approval to undergo a second phase of trials on the investigational device, Intrastromal Corneal Ring (ICR), produced by KeraVision, Inc. The device is designed to reduce or eliminate the need for glasses or contacts in near-sighted people. It is a transparent ring, approximately seven millimeters in diameter that will be implanted within the cornea to reshape the curvature. Five people will receive the ICR implants through a brief outpatient procedure in the first clinical study of sighted people using this procedure.

The division of endocrinology has opened an intensive diabetes management clinic. The clinic provides a direct phone line for patients to discuss their blood sugar levels and adjust their insulin at any time. Patients are supervised by a diabetes management team and will receive intensive diabetes education.

Washington University

Arthur Eisen, MD, professor of medicine, has been given the Stephen Rothman Memorial Award from the Society for Investigative Dermatology. The award was established in 1966 to recognize distinguished service to investigative cutaneous medicine. Dr. Eisen's research focuses on studying a family of enzymes known as extracellular matrix metalloproteinases which are responsible for degrading important connective tissue proteins.

Lee N. Robins, PhD, professor of social science in psychiatry, has been honored by the College on Problems of Drug Dependence with the 1993 Nathan B. Eddy Award. The award is given annually to honor the career of a scientist who has made outstanding contributions to the field of drug abuse research.

L. David Sibley, PhD, assistant professor of molecular microbiology, received one of three Burroughs Wellcome Fund New Investigator Awards in Molecular Parasitology for 1993. The award will support studies on the biology of *Toxoplasma gondii*, a protozoan parasite that infects virtually all types of nucleated vertebrate cells. *Toxoplasma* is emerging as a major opportunistic pathogen in the United States, occurring in 10-30% of AIDS patients.

Researchers at Washington University and Barnes Hospital have concluded that a blood test used in conjunction with a rectal exam to detect cancer dramatically increases the likelihood of finding cancers while they are still curable. The large-scale, multi-center study included 6,400 men over the age of 50.

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Together, the two tests nearly doubled the percentage of curable cancers detected by rectal exams alone. 96% of the prostate cancers detected exclusively by the blood test were serious cancers, as opposed to many of the small, insignificant prostate tumors that do not require treatment. The blood test measures levels of prostate-specific antigen (PSA), a protein produced exclusively in the prostate gland.

Anu Dixit, PhD, a NIH fellow at Washington University, has identified the allergenic proteins of a little-known but major allergen that threatens regardless of season. Epicoccum nigrum (EN), a fungus, can be found everywhere - clothes, drapes, air-conditioning ducts, plants, rocks and soil. Dr. Dixit's study is the first to show that allergenicity to EN is a concern in two climatologically distinct areas of the country - St. Louis and Corpus Christi, Texas. She distinguished allergenicity between the EN spores and its mycelia, both of which become airborne. Her work points out the inadequacy of commercial extracts which are prepared primarily with fungal mycelia only.

James S. Kemp, MD, assistant professor of pediatrics, and **Bradley T. Tach, MD,** professor of pediatrics, have studied the problem of rebreathing, a form of accidental infant suffocation. Their work has helped lead to the banning of polystyrene-filled cushions by the Consumer Product Safety Commission. and was cited by the American Academy of Pediatrics when making their recommendation that infants sleep on their backs for sides. Drs. Kemp and Tach found that face-down infants can breathe air that becomes trapped with the bedding around the baby's face. This rebreathing of carbon dioxide can lead to accidental suffocation. One goal of their work is to develop a quantitative measurement of the softness of bedding to figure out what degree of softness poses a hazard to sleeping infants.

Washington University will participate in a multi-center study evaluating various hormone replacement therapy regimens and doses in post-menopausal women. The Upjohn Co. is funding the one-year study involving 480 women from 15 centers throughout the nation. The medical school will recruit 25 women from the St. Louis area to participate.

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Life at the Phi Bete House, Columbia, Mo. 1937-1938

John A. Carrier, MD

The Phi Bete Castle Song

I'm gonna build me a Castle
painted green and white
Gonna have a Bull Fest
every night
Skeleton bones all over the floor
and a Phi Beta Crest hanging over
my door.
Gonna marry a gal from old Mizzou
Bloods gonna turn from red to blue
Entertaining Royalty every night
in a Castle painted green and white.

I lived in the Phi Beta Pi house the two years I attended the University of Missouri School of Medicine. The house was located at 718 Maryland, south of Conley Road. This was nice walking distance from The Topic, the Shack, Gaeblers, and the little corner grocery store where we bought candy bars and Cokes on the way home from school.

Phi Beta Pi was a national medical fraternity, with many illustrious alumni who supported it proudly, and many showed up regularly for homecomings or championship football games. However, by today's standards the House was truly a "Dump or Firetrap." Regardless, a student could live there very reasonably, enjoy simple but good meals, and have the advantage of living with others trying to achieve the same goals.

Moving in with me that fall of 1936 from Drury College in Springfield were Orin Davidson, Earnest Noblitt, Arthur Dalton, Eugene Brewer. From State Teachers College were Earl Bassham and Charles Johnson. Other newcomers were Fred Biggs, Jim Cope, Eugene Windmiller, J. Ashley, and George Robertson from other parts of the state. The second year occupants included John Allen, Eldon Mohler, Gene Farthing, Stanley Roper, Bill Summers, and others whose names I can't recall at this sitting.

For House chaperons we were fortunate to have Dr. and Mrs. Leman Wells. Leman and Elsie were a young couple in their upper twenties. He was our instructor in Embryology and filled in for Dr. Milton Overholser in Anatomy when necessary. He was a PhD but took classes along with us from time to time earning credits toward his MD. During one summer he went to Colorado and dissected an entire cadaver during a school session, working long hours and weekends.

Leman felt the strain of studies, and the sedentary life we led should be changed. So he had us jogging and running after classes south of the campus to an area where the Medical Center now stands. Also, in the winter months we split firewood and in the spring played catch or passed footballs.

There was another sport that the Phi Betes enjoyed that wasn't on Dr. or Mrs. Well's Bulletin Board Schedule. That was Girl Watching! Maryland Street was the main concourse for the girls to walk from campus to their sorority or rooming houses south of our place. The fraternity brothers would sit on the front porch or the steps and gaze at the attractive young women in their snug fitting sweaters and skirts. Being used to classifying parts in Anatomy class for Dr. Milton Overholser, it wasn't unexpected that they would classify the chest contours of the girls as they paraded by. I'm certain their efforts would not have been appreciated by the girls or Dr. Overholser. Fortunately, their comments were made quietly to each other--no loud talk or shouting. Even in those days there might have been awareness of harassment, but we probably didn't call it that.

In my original draft of this article I included the classification, but when my wife looked over my shoulder and read the copy, I decided to delete that paragraph.

THE FIDDLE-DE-FEE HOUSE

The Phi Delta Phi Law Fraternity House was located at 715 Hill Street across from the girls' gymnasium. If we thought the Phi Bete House was a rat-trap, you hadn't seen anything until you visited the Fiddle-De-Fee Barn.

Luckily, three or four of us were invited there on Saturday night for dinner, and then afterwards attended a basketball game. Some of the members were old friends of ours from Drury College. Among those were John D. Hulston, Milton Kirby, Ellsworth Haymes, Dave Woodruff, Carlton "Cot" Hastletine, Walt Langston, Bill Wear, Lyndon Sturgis, and Bob O'Day. The long suffering house mother was Miss Frances Wise, a pleasant elderly white-haired lady, who greeted us in the parlor, with our smiling

Springfield friends standing behind her. Ellsworth Haymes introduced us to her and in his position behind her said, "Well, you old SOB can't you say something else besides --Howdoyudo, young Doctors? -" Davidson, Whitten and I almost fell over in a state of shock. Following a few more remarks like that it dawned on us that Miss Wise was practically stone deaf.

Haymes said we should go up to his room on the second floor for a drink. Someone poured us a drink of Bourbon in a glass, then Ellsworth yelled down the hall. "Send us the Ice!" Another student stepped out of his room, and pushed a 25 lb. cake of ice down the hall to us. With an ice pick we obtained our ice for the drinks. Looking about the rooms we saw beat-up furniture, former tenants' initials carved all over the doors, and bullet holes in the ceiling where at one time someone had done a bit of target practice from his bed.

The dining room was in the basement with steam and water pipes exposed. Davidson asked how they elected the president of the fraternity. The answer was, "Whoever can take a piece of pie on a plate, throw the pie over the pipes and catch it in the plate intact is the president."

There was one more shocker for us that evening. A few of the boys brought dates for dinner. One of our friends brought a well-known hooker from downtown -- just to see the expression on our faces!

During our second year at the Phi Bete House those of us who were elected officers had the good fortune of being invited routinely to all the Greek Letter social functions. This policy held true to dances and functions at Stevens and Christian colleges also. As medical students we usually felt somewhat removed from the rest of the campus, but our visits to these fancy gatherings made us feel we were really moving with the "in crowd."

As a result, we were exhilarated when the invitations arrived for us to attend the big Panhell Dance with Ted Weems and his Band. It was formal, so we wore dark suits. None of us could afford to rent Tuxedos. Orin Davidson, Foster Whitten, and I walked over to the Rothwell Gym where this shin-dig was being held. The newspaper stated there should be about 900 students attending. There was certainly a huge beautiful crowd gathered with most of the fellows slicked up in their tuxes and the girls in their gorgeous long formals. The three of us edged up to the band stand to watch the band set-up. Perry Como was just starting his illustrious career as a male vocalist with the band. He was a bit overweight in those days, but moving around briskly setting up the music stands and passing out the musical arrangements. He was very friendly and talked with us as he completed his chores. Later when he sang we were impressed with his beautiful voice. Ted Weems was relaxed and sociable too. We ask him about Joe Haymes and his band. Ted had sponsored Joe after hearing him in Springfield, Missouri. Joe and his boys were on tour making a great reputation for themselves. Ted agreed to play some Joe Haymes arrangements later in the evening.

As the evening progressed a problem developed. Davidson was used to having about one drink of Four Roses blended whiskey per social evening. To be friendly, he accepted another drink or two from a generous Sigma Nu. The Jack Daniel label had a bit more punch than the good ole Four Roses. Soon I was supporting him by his arm and weaving back and forth with him. Professor Jesse Wrench was one of the chaperons. I recognized his face, his long hair and beard, but he looked different in a Tux. During the school week he wore a hair net, knickers, and rode a bicycle to class.

Professor Wrench came up to me and said, "I've been keeping my eye on you. If you don't straighten up, I'll throw you our of this joint."

What a surprise. I was cold sober, and he hadn't said a word to Davidson! It was certainly time to get Davidson back to the house. WE walked him back, put him to bed, and few of the other brothers came by to see what was going on. One of them had the bright idea of painting Orin's face with watercolors. These were real handy since there was someone always working on Pathology notebooks with such colors. Consequently, the best artist in the group applied the paint and poor Davidson looked like a Comanche after a losing battle, or the monster from the Black Lagoon. Someone was appointed to awake the others when he got up the following morning and looked in the mirror. However, Davidson was the only one in the House that habitually got up early on Sunday morning to attend church. So the look on his face on gazing in the mirror was missed by all. He was a bit upset about the treatment, but laughed about it later.

THE CLASS OF 1938

There were about forty of us in the class during the first semester of 1937. Twenty-nine of us left there at the end of the second year with a BS in Medicine. Missouri University Medical School was two-year program, so each student had to transfer to another institution to complete the last two years. They scattered all over the United States. Some to Washington University in St. Louis; some to Rush in Chicago; some to Northwestern; two to Harvard; one or two to New York; two or three to Louisville; one to the University of Virginia, and I finished at the University of Tennessee at Memphis.

Through the efforts of Drs. Carl Siegel and Ben Jolly annual reunions have been arranged and one is scheduled for next October. Several members have passed away as the years roll by but all that we have followed have done exceptionally well in their chosen fields. As to our friends, the Fiddle-de-Fees, at the Law School - how did they do? Those that we knew became outstanding and prominent attorneys in Missouri.

The Changing Image of the American Physician

Craig Carmichael

From 1900 to 1960, the image of the American physician improved steadily and dramatically due to advances in science and improvements in medical education which were initiated by the AMA. During this time, the media shifted from producing daily newspaper accounts about physician fraud and butchery to creating endearing movies such as "Dr. Kildare." In 1965 Congress respected physicians enough to create Medicare/ Medicaid rules under which doctors could literally name their price. At this time, historian John Duffy wisely wrote, "The new status of the American physician carries with it a heavy burden of responsibility. Economic success, a frequent corollary of high status, often engenders complacency and in many subtle ways influences moral judgments...[Doctors'] status in American society today requires an even greater obligation to live up to their social responsibilities."[1]

Whether due to physician irresponsibility or increasing expectations of the American public, the image and freedom of the American physician has been declining in recent years. In 1981 Congress enacted laws which penalized physicians for overcharging Medicare/ Medicaid and in 1983 the DRG system was born. Other recent developments include the tendency for insurance company representatives who have no medical training to tell doctors how to treat their patients, an increased willingness for juries to reach large malpractice decisions, and the assessment of new taxes aimed specifically at health care providers.

Of course, the clearest sign of distrust for physicians is the popularity of the idea of health care reform, which carries with it the idea that doctors must be restrained under the new system. Of the more than 500 members of the Health Care Reform Task Force, lawyers far outnumbered the 60 MDs, and only 9 task force members were not in the employ of a government agency.

Without doubt, the declining respect for physicians has begun to impair their ability to practice medicine. Physicians order unnecessary tests to avoid being sued, or forego effective treatments because the treatments are denied by Medicare.

Physicians are not likely to retrieve their power and autonomy anytime soon. As AIDS and antibiotic resistant diseases increase in prevalence, doctors may appear somewhat powerless and ineffective. At the same time, our populace will be demanding more care, cheaper prices, and continued malpractice awards. Universal coverage and cheaper prices by definition requires that doctors see more patients and take a smaller paycheck; but, more importantly, it means that doctors will have to fight for every dollar that they are allowed to spend on their patient, since a rationing system will be in place.

In this new era of increasing distrust, good medical practice requires good politics. In the past few decades, doctors could afford not to be politically involved because their decisions were unquestioned and their power and authority were unrestrained. Today, however, doctors must return to the same system which increased their prestige in the first place -- activism in the AMA. Just as the AMA reformed medical education and activated regulatory standards at the turn of the century, it must now lead the reform in the health care distribution, rationing, and malpractice systems.

Medical school is the best time to get involved. Student membership in the Missouri State Medical Association costs only $15/yr and includes a subscription to *Missouri Medicine.* AMA membership is only $64 for 4 years and includes a subscription to *JAMA* and the AMA Drug Evaluations book, a book which lists for $95. Students participate at national meetings, state meetings and local chapter meetings and help organize letter-writing campaigns, recruit speakers, and write resolutions which become national AMA policy. In the past year, Missouri students authored 5 resolutions which became national medical student policy, and two of these five have already become national AMA policy.

Medical students and physicians alike should not be disheartened at the changing image of the American physician. Physicians have historically battled with adverse practice conditions and public distrust, only to raise themselves to new heights in terms of skill, professionalism, and national organization.

---

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Craig Carmichael, a medical student at Washington University, St. Louis, Missouri, is chairman of the MSMA Medical Students Section.

Call for Papers

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The 1994 International Conference on Physician Health, co-sponsored by the American Medical Association, the Federation of State Medical Boards, the Canadian Medical Association, and the Federation of Medical Licensing Authorities of Canada is scheduled for September 14-18, 1994, at the Ottawa Westin Hotel.

Ottawa is Canada's capital and offers many national museums, over 60 miles of bicycle paths, hiking in Gateneau park, squash courts and swimming at the hotel and golf nearby.

The conference will provide a forum for practitioners and researchers to present recent findings and innovative treatment and education programs in physician health. This conference will address a range of issues, such as AIDS, HIV, problems related to aging, mental illness, substance abuse and physical disabilities and limitations, including those caused by general medical conditions. Possible topics for presentation include: presentation and treatment of health problems among physicians, the impact of disorders on physicians' families and practices, medical-legal issues facing hospital administrations and licensing boards, and material on health promotion and disease prevention. *Abstracts which address issues related to these topics (i.e., prevention, diagnosis, treatment, rehabilitation), but not dealing specifically with physicians are also welcome.*

Three types of presentations regarding these physician health issues are invited:

- **Poster Presentations**
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- **Paper Sessions**
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  Abstracts for poster presentations and paper sessions should contain an introductory statement on the significance of subject matter. Description of methods, results, and conclusions should follow the introductory statement.

- **Workshops**
  Training or instructional presentations, designed to improve specific skills of persons who work in the area of physician health.

  Abstracts for workshops should contain information on the program's intended audience, goals, teaching strategies, and materials. Evaluation data should be summarized

Abstracts may not exceed 200 words. Any abstracts exceeding that length will be rejected. Abstracts should be typed, double spaced, and mailed (not faxed). Four copies of the abstract should be sent, along with one self-addressed, stamped envelope. All submissions must list the primary and secondary authors and their professional affiliations. Telephone number and address of primary author must also be included.

Submissions *must* be received by February 1, 1994.

Abstracts will be submitted for blind review. Abstracts will be judged on their applicability to the conference topic area and their scientific merit. The decisions of the blind reviewers will be communicated to the abstract's primary author by April 1, 1994.

All presenters are expected to register for the conference at the AMA member rate. We are unable to provide any financial support for presenters. Presenters will also be responsible for their own transportation and hotel expenses, as well as making all reservations for same.

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AUDRAIN

Harold D. Lankford, *Mexico*

BOONE

John J. Morris, *Columbia*
David M. Schlossman, *Columbia*
William M. See, *Columbia*
Myrl E. Windmiller, *Columbia*

BUCHANAN

Theodore C. Kiekhaefer, *St. Joseph*

CAPE GIRARDEAU

Mark C. Kasten, *Cape Girardeau*
Mohammad Shakil, *Cape Girardeau*

CLAY-PLATTE

Larry E. Benson, *N. Kansas City*
Patricia A. Young, *Kansas City*

COLE

Thomas J. Hancock, *Jefferson City*

DUNKLIN

Soros Tungsiripat, *Kennett*

FRANKLIN-GASCONADE-WARREN

George A. Richardson, *Union*

GREENE

H. Mark Crabtree, *Springfield*
Gary L. Hoos, *Springfield*
William K. Rosen, *Springfield*
Warren T. Wilson, *Springfield*

JASPER

Lowell K. Pottenger, *Joplin*

METRO MED OF KANSAS CITY

Federico Adler, *Kansas City*
Thomas P. Allen, *Kansas City*
Chester I. Bare, *Kansas City*
Steven E. Buie, *Kansas City*
James E. Carter, *Kansas City*
Sherman W. Cole, *Kansas City*
Thomas H. Good, *Kansas City*
Robert E. Gunnoe, *Kansas City*
Michael F. Hughes, *Kansas City*
Rosalyn E. Inniss, *Kansas City*
Andrew McCanse, *N. Kansas City*
Ruth E. Millett, *Kansas City*
Michael L. Munger, *Kansas City*
Carl M. Myers, *Platte City*
Sharon R. Snavely, *Kansas City*
Donald W. Thibeault, *Kansas City*
Gary S. Wasserman, *Kansas City*
W. Joel Wurster, *Kansas City*

MID-MISSOURI

Richard H. Matthews, *Rolla*

MINERAL AREA

Patrick E. Johnson, *Farmington*

NORTHEAST

Earl L. Rapp, *Hannibal*
Lynn J. Walley, *Hannibal*

NORTHWEST

James K. Hunter, *Fairfax*

ST. CHARLES-LINCOLN

Thomas A. Schneider, *St. Charles*

ST. LOUIS METROPOLITAN

Victor H. Albera, *St. Clair*
Fernando Arias, *St. Louis*
Carl N. Baker, *St. Louis*
Lata R. Bagwe, *St. Louis*
Duane Q. Hagen, *St. Louis*
Michael R. Handler, *Kirkwood*
Samuel Krain, *St. Louis*
Suzanne L. Miller, *Glencoe*
Philip L. Robbins, *St. Louis*
James C. Sisk, *St. Louis*
Dieter H. Wurr, *Arnold*

SOUTH CENTRAL

David O. Barbe, *Mountain Grove*

IN MEMORIAM

■ **Lauren V. Ackerman, MD,** St. Louis, Missouri, died July 27, 1993, at age 88. Dr. Ackerman received his medical degree at the University of Rochester, New York, in 1932. In 1940 he began working at the old State Cancer Hospital in Columbia, Missouri and later became medical director. He was appointed professor of surgical pathology and pathology at Washington University School of Medicine in 1948. Dr. Ackerman also served as director of the school's division of surgical pathology. After 25 years of teaching at Washington University he retired in 1973 and moved to New York. He out of retirement to teach pathology at the State University of New York, Stoney Brook. Dr. Ackerman published more than 200 scientific articles and abstracts on surgical pathology, including *Cancer - Diagnosis, Treatment and Prognosis* and *Surgical Pathology*. He has been credited with establishing surgical pathology as a separate medical specialty. The new surgical pathology laboratory at Washington University was named in Dr. Ackerman's honor in 1990. He was also awarded the school's Distinguished Service Award. Dr. Ackerman was a member of the International Academy of Pathology, the American College of Pathologists, the American Society of Clinical Pathologists, and the American Society for Experimental Pathology.

■ **Willard Allen, MD,** St. Louis, Missouri, died August 2, 1993, at age 88. Dr. Allen received his medical degree at the University of Rochester, New York, in 1932. From 1940 to 1971, he was head of the department of obstetrics and gynecology at Washington University School of Medicine. Dr. Allen first taught at the University of Rochester. In 1935, he received the Eli Lilly Award in biological chemistry for the isolation in pure form of progesterone. Dr. Allen retired from Washington University in 1971, but came out of retirement to join the faculty of the medical school at the University of Maryland. He taught until 1982. Dr. Allen was a member of the American Association of Obstetrics & Gynecology, the American Gynecological Society, the American College of Obstetricians & Gynecologists, and the American College of Surgeons.

■ **Eugene C. Beatty, Jr., MD,** Overland Park, Kansas, died August 13, 1993, at age 71. Dr. Beatty received his medical degree at the University of Colorado School of Medicine in 1943. He was a pathologist at Denver Children's Hospital from 1954 to 1968. He then became a pathologist at Children's Mercy Medical Hospital and practiced there for 25 years. He was a flight surgeon at Lowry Air Force Base and served in the Army Air Forces for two years. Dr. Beatty was a member of the Metropolitan Medical Society of Greater Kansas City, Missouri State and American Medical Associations, the American Board of Pathologists, the American Society of Clinical Pathology, and the College of American Pathologists.

■ **Hector W. Benoit, Jr., MD,** Kansas City, Missouri, died May 21, 1993, at age 73. Dr. Benoit received his medical degree at Long Island College of Medicine, Brooklyn, New York, in 1944. He was a thoracic surgeon in Kansas City from 1953 until retirement in 1983. Dr. Benoit was a former treasurer and member of the executive council of the Metropolitan Medical Society of Greater Kansas City. He received the 1973 Merit Award. He was a former treasurer, member of the executive council and past president of the Missouri State Medical Association. He served as a delegate to the American Medical Association's House of Delegates. Dr. Benoit was a member of the American Medical Association Council on Medical Services, the Southwestern Surgical Congress, the American College of Surgeons, the American Association for Thoracic Surgery and the American College of Chest Physicians.

■ **William H. Bryan, Jr., MD,** Kansas City, Missouri, died June 13, 1993, at age 76. Dr. Bryan received his medical degree at the Meharry Medical College, Nashville, Tennessee, in 1944. He practiced as a surgeon with another specialty in industrial medicine. Dr. Bryan began practice in Kansas City in 1951. He was Jackson County coroner from 1969 to 1971. Dr. Bryan was a member of the Southwestern Surgical Congress, the American Occupational Medical Association the Metropolitan Medical Society of Greater Kansas City and American Medical Association.

■ **Sol F. Canto, DO,** St. Louis, Missouri, died June 4, 1993, at age 56. Dr. Canto received his doctor of osteopathy at the Kirksville College of Osteopathic Medicine in 1961. He was in private practice for ten years in Columbus, Ohio for ten years before moving to St. Louis. Dr. Canto practiced emergency medicine until 1987 when opened the Sunset Hills Family Medical Practice. At this office he sponsored community education courses. He most recently was on the staffs of Missouri Baptist, Incarnate Word and Deaconess hospitals. Dr. Canto was on the board of the Southwest County unit of the American Cancer Society. He was a member of the St. Louis Metropolitan Medical society, the Missouri State Medical Association and the American Academy of Physicians.

■ **Cyril J. Costello, MD,** St. Louis, Missouri, died June 15, 1993, at age 77. Dr. Costello received his medical degree at the University of Texas, Galveston, in 1939. He was a surgeon in St. Louis for 45 years. Dr. Costello was medical director of the old City Hospital and chief surgeon for the Labor Health Institute. He was past president of both the Southwestern Surgical Society and the Missouri State Surgical Society. Dr. Costello also was a director and co-founder of the Hodgen's Surgical Society of St. Louis. He was on the staffs of Barnes Hospital and St. John's Mercy Medical Center. Dr. Costello was a member of the Western Surgical Association, The Southwestern Surgical Congress, the International College of Surgeons and the American College of Surgeons.

■ **Desmond Curran, MD**, Mission Hills, Kansas, died May 18, 1993, at age 86. Dr. Curran received his medical degree at the University of Kansas in 1932. He practiced ophthalmology in Kansas City since 1932. Dr. Curran was a member of the American Academy of Ophthalmology and Otolaryngology.

■ **Lloyd A. Hollinger, MD,** Prairie Village, Kansas, died June 3, 1993, at age 59. Dr. Hollinger received his medical degree at the University of Kansas in 1960. He began private practice in 1967 and was on the staffs of Research Medical Center and St. Joseph Health Center. Dr. Hollinger was vice president in charge of medical affairs at Baptist Medical Center and formerly was director of pulmonary and respiratory medicine. He was past president of the medical staff at Baptist Medical Center and formerly was the medical director of the school of respiratory therapy at Johnson County Community College. Dr. Hollinger was past president of the Kansas Thoracic Society and the Northeast Kansas Lung Association. He was a member of the American Thoracic Society, the Missouri State and American Medical associations and a fellow of the American College of Chest Physicians.

■ **Claude K. Leeper, MD,** Columbia, Missouri, died June 14, 1993, at age 72. Dr. Leeper received his medical degree at Washington University in 1946. He began his medical as an assistant professor of pathology at the University of Missouri-Columbia in 1949. In 1958 he joined the Air Force and retired as a colonel in 1974. He then returned to MU Medical School as a professor in the Department of Pathology. He retired from teaching in 1987. Dr. Leeper was a member of the College of American Pathologists, the American Society of Clinical Pathologists, the Association of Military Surgeons of the United States and the International Academy of Pathology.

■ **Jacob G. Probstein, MD,** St. Louis, Missouri, died May 23, 1993 at age 99. Dr. Probstein received his medical degree at the Loyola University in 1917. After serving as a naval officer during World War I, he began his practice in St. Louis. He was chief of surgery at Jewish Hospital for eight years. He was a founder of the Missouri Cancer Commission in 1962. Dr. Probstein was the last team doctor of the St. Louis Browns and the first team doctor of the St. Louis Blues. He continued his attendance at the hockey games until the last two years. Dr. Probstein was also the physician for the Koplar family's hotel and theater interests. He taught surgery and anatomy at Washington University. His research contributions include many papers, two books and hundreds of thousands of dollars raised and contributed to medical projects. The Missouri Cancer Research Center made him an honorary lifetime board member. He was also a member of the American College of Surgeons, Society of Surgery for the Alimentary Tract, the American Branch of the International Society of Surgery and the Southwestern Surgical Congress.

■ **Dorothy D. Reister, MD,** Overland Park, Kansas, died July 8, 1993, at age 67. Dr. Reister receive her medical degree at Washington University, St. Louis, in 1950. She began her career as a pediatric instructor at Washington University and St. Louis Children's Hospital. In 1956 Dr. Reister started practice as a pediatrician in Kansas City and Johnson County. From 1956 to 1969 she worked for the Well Baby Clinics in Kansas City. Dr. Reister was on the staffs at Research Medical Center, Baptist Medical Center, St. Joseph Health Center and St. Luke's Hospital. She was a member of the Metropolitan Medical Society of Greater Kansas City, the American Medical Women's Association, the Greater Kansas City Pediatrics Society and the Missouri chapter of the American Academy of Pediatrics. Dr. Reister served president of the Jackson County Medical Society in 1986; chairman of the Missouri State Medical Association in 1988; and president of MSMA in 1991.

■ **Truman B. Schertz, MD,** Kansas City, Missouri, died June 8, 1993, at age 79. Dr. Schertz received his medical degree at the University of Illinois, in 1941. He was an ophthalmologist practicing in Kansas City and North Kansas City from 1955 to 1990. Dr. Schertz was past medical staff president and a former member of the board of directors at North Kansas City Hospital. He was a member of the Clay-Platte County Medical Society, the Missouri and American Medical Associations and the American Society of Ophthalmology. Dr. Schertz was past president of the Missouri Ophthalmological Society Inc. He was a fellow of the American Academy of Ophthalmology and Otolaryngology and the Society of Eye Surgeons of the International Eye Foundation and an ophthalmological associate of Research to Prevent Blindness.

DISCIPLINARY ACTIONS

The following is a listing of final disciplinary actions taken by the State Board of Registration for the Healing Arts. The listing includes actions finalized through June 1, 1993. This information is made available to the public under the provisions of Section 334.101 RSMo. Underlined names indicate members of the Missouri State Medical Association.

STEVEN STREET, DO, Springfield, Missouri, Past history of personal impairment.
Violation Section 334.100.2 (4) (8) (22) RSMo Supp. 1990
Board Action: Five (5) year probation with terms and conditions. Effective 4/2/93

ROBERT K. GOODLOE, DO, Mustang, Oklahoma, Felony conviction.
Violation 334.103 RSMo Supp. 1986
Board Action: Revocation of Missouri license with no reinstatement for seven (7) years. Effective 4/27/93

DEJA SUTHIKANT, MD, St. Joseph, Missouri, Disciplinary action taken in another state.
Violation Section 334.100.2 (8) (23) RSMo Supp. 1988
Board Action: Revocation of Missouri license, with immediate reinstatement. The Board also ordered that the remainder of Dr. Suthikant's probation be terminated. Effective 4/12/93

ELMER L. BARRETT, MD, Salt Lake City, Utah, Disciplinary action taken in another state.
Violation 334.100.2 (4) (h) (5) (8) RSMo Supp. 1986
Board Action: Voluntary surrender of Missouri license with no reinstatement for seven (7) years.
Effective 3/4/93

JOSEPH MARMET, MD, Los Angeles, California, Disciplinary action taken in another state.
Violation 334.100.2 (2) (4) (5) (8) RSMo
Board Action: Revocation of Missouri license with no reinstatement for seven (7) years. Effective 3/15/93

STEVEN H. McGUIRE, DO, Odessa, Missouri, Felony conviction for sexual assault.
Violation 334.103 RSMo Supp. 1986
Board Action: Revocation of Missouri license with no reinstatement for seven (7) years. Effective 3/16/93

LEO M. KRAMER, MD, Columbia, Missouri, Board Action: Voluntary surrender of Missouri license with no reinstatement for seven (7) years. Cannot reapply unless approved by the Board. Effective 3/15/93

JAMES STRICKLAND, MD, St. Louis, Missouri, Performed wrong surgery on patient.
Violation 334.100.2 (5) RSMo Supp. 1984
Board Action: Formal reprimand of Missouri license.
Effective 3/17/93

JAYEN C. SHAH, MD, St. Louis, Missouri, Misrepresentation in the performance of the functions and duties of a physician.
Violation 334.100.2 (4) RSMo 1987
Board Action: Voluntary surrender of Missouri license with no reinstatement for seven (7) years.
Effective 3/26/93

RAY W. OLDFIELD, MD, Kansas City, Missouri, Past history of personal impairment.
Violation 334.100.2 (4) (5) (8) (22) RSMo Supp. 1987
Board Action: Voluntary surrender of Missouri license with immediate reinstatement on five (5) years probation with terms and conditions. Effective 3/26/93

CHARLES A. WALTZ, MD, Ft. Meyer, Florida, Disciplinary action taken in another state.
Violation 334.100.2 (4) (5) (8) RSMo. Supp. 1990
Board Action: Revocation of Missouri license with no reinstatement for seven (7) years. Effective 4/5/93

JOHN SIMPSON, MD, Clayton, Missouri, Past history of personal impairment.
Violation 334.100.2 (1) (4) (5) (25) RSMo Supp. 1992
Board Action: One (1) year probation with terms and conditions. Effective 4/8/93

VICTOR ALEXANDER, MD, New Orleans, Louisiana, Felony conviction.
Violation 334.103 RSMo Supp. 1986
Board Action: Revocation of Missouri license with no reinstatement for seven (7) years. Effective 4/5/93
Appealed to Circuit Court on 5/10/93.

WALTER L. LONG, DO, Detroit, Michigan, Disciplinary action taken in another state.
Violation 334.100.2 (1) (4) (5) RSMo Supp. 1990
Board Action: Revocation of Missouri license with no reinstatement for seven (7) years. Effective 2/11/93

LEO O. FURR, MD, Bird Island, Minnesota, Disciplinary action taken in another state.
Violation 334.100.2 (2) (4) (h) (5) (8) (13) RSMo Supp. 1986
Board Action: Revocation of Missouri license with no reinstatement for seven (7) years. Effective 2/11/93

GAIL A. CLARK, MD, St. Louis, Missouri, Violation of probation agreement.
Violation 334.100.2 (4) (o) RSMo Supp. 1991
Board Action: Formal Reprimand of Missouri license. Effective 2/22/93

ALI ABDEL-RAHIM KHOLEIF, MD, Woodland, Texas, Disciplinary action taken in another state.
Violation 334.100.2 (4) (5) (8) RSMo Supp. 1990
Board Action: Revocation of Missouri license with no reinstatement for seven (7) years. Effective 2/22/93

JAMES D. PAYNE, DO, Bay City, Michigan, Disciplinary action taken in another state.
Violation 334.100.2 (8) RSMo Supp. 1991
Board Action: Revocation of Missouri license with no reinstatement for seven (7) years. Effective 2/11/93

JONAS TEJERO, MD, St. Charles, Missouri, Unlawful practice of medicine resulting from his failure to retain a current Missouri license.
Violation 334.100.2 (6) RSMo Supp. 1991
Board Action: Two (2) years probation with terms and conditions. Effective 1/28/93

ROBERT A. KOMER, DO, Montgomery, Texas, Disciplinary action taken in another state.
Violation 334. 100.2 (4) (i) (8) (13) RSMo Supp. 1991
Board Action: Revocation of Missouri license with no reinstatement for seven (7) years. Effective 2/11/93

JOHN C. LONG, MD, Santa Ynez, California, Disciplinary action taken in another state.
Violation 334.100.2 (4) (i) (5) (8) RSMo Supp. 1990
Board Action: Revocation of Missouri license with no reinstatement for seven (7) years. Effective 2/11/93

MEHDI ZARABI, MD, Blue Springs, Missouri, Disciplinary action taken in another state.
Violation 334.100.2 (4) (8) RSMo Supp. 1990
Board Action: Formal reprimand of Missouri license. Effective 2/8/93

JOSEPH C. UNGVARI, MD, St. Louis, Missouri, Non therapeutic prescribing.
Violation 334.100.2 (4) (h) (5) RSMo Supp. 1987
Board Action: Three (3) years probation with terms and conditions. Effective 11/1/92

SARZ MAXWELL, MD, Chicago, Illinois, Prescribed controlled substances to persons without establishing physician-patient relationship and prescribed amphetamines in the names of other persons then used herself.
Violation 334.100.2 (4) (h) (5) (22) RSMo Supp. 1990
Board Action: Voluntary surrender of Missouri license with immediate reinstatement under a seven (7) year probation with terms and conditions. Effective 1/28/93

JOHN C. MARTZ, MD, Frontenac, Missouri, Treating family members and himself without proper records.
Violation 334.100.2 (4) (h) RSMo Supp. 1988
Board Action: License restricted indefinitely with terms and conditions. Effective 1/6/93

CARLOS M. RUIZ, MD, St. Louis, Missouri, Medical incompetence.
Violation 334.100.2 (25) (f) RSMo
Board Action: Revocation of Missouri license with no reinstatement for three (3) years. Effective 12/30/92

RANDOLPH McKENZIE, MD, Kansas City, Missouri, History of personal impairment.
Violation 334.100.2 (1) (5) (22) RSMo Supp. 1990
Board Action: Five (5) years probation with terms and conditions. Effective 1/1/93

JERRY B. WURSTER, MD, Kansas City, Missouri, History of personal impairment.
Violation 334.100.2 (13) (4) (h) RSMo
Board Action: Voluntary surrender of Missouri license with immediate reinstatement under seven (7) years probation, retroactive 8/1/90. Effective 8/1/90

SHAMS H. ARASTU, MD, Harper Woods, Michigan, Disciplinary action taken in another state.
Violation 334.100.2.(4) (g) (5) and (8) RSMo
Board Action: Three (3) years probation with terms and conditions. Effective 10/1/92

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NEW MEMBERS

❖ **Steven M. Abbadessa, DO,** 530 Des Pere Rd., St. Louis, MO 63131, has become a member of the Missouri State Medical Association. Dr. Abbadessa received his doctor of osteopathy at Kirksville College of Osteopathic Medicine in 1984. He completed his residency at Normandy Osteopathic Hospital. Dr. Abbadessa specializes in proctology.

❖ **Douglas R. Adkins, MD,** 3635 Vista Ave., St. Louis, MO 63110, has become a member of the Missouri State Medical Association. Dr. Adkins received his medical degree at Wright State University, Dayton, OH, in 1986. He completed his residency at the University of Texas Health Science Center, San Antonio. Dr. Adkins specializes in oncology.

❖ **Richard C. Aiken, MD,** 202 E. Fifth St., Washington, MO 63090, has become a member of the Franklin, Gasconade and Warren County Medical Society. Dr. Aiken received his medical degree at the University of Utah in 1989. He completed his residency at Washington University. Dr. Aiken specializes in psychiatry.

❖ **Constance M. Barone, MD,** One Hospital Drive, Columbia, MO 65212, has become a member of the Boone County Medical Society. Dr. Barone received her degree at Mount Sinai School of Medicine, New York, in 1978. She completed her residency at New York University Medical Center. Dr. Barone specializes in plastic and reconstructive surgery.

❖ **Emory C. Beechwood, MD,** 1624 Delmar, St. Louis, MO 63103, has become a member of the St. Louis Metropolitan Medical Society. Dr. Beechwood received his medical degree at St. Louis University in 1959. He completed his residency at St. Mary's Health Center, St. Louis. Dr. Beechwood specializes in nephrology.

❖ **Steven W. Bigg, MD,** 11125 Dunn Rd., Suite 208, St. Louis, MO 63136, has become a member of the St. Louis Metropolitan Medical Society. Dr. Bigg received his medical degree at Northwestern University in 1986. He completed his residency at Barnes Hospital. Dr. Bigg specializes in urology.

❖ **Michael J. Bolesta, MD,** 400 Keene St., Columbia, MO 65201, has become a member of the Boone County Medical Society. Dr. Bolesta received his medical degree at the University of Missouri-Columbia in 1981. He completed his residency at Duke University, Durham, NC. Dr. Bolesta specializes in orthopedic surgery.

❖ **Martha A. Brehm, MD,** 1030 McIntosh Circle Dr., #1, Joplin, MO 64804, has become a member of the Jasper County Medical Society. Dr. Brehm received her medical degree at the University of Oklahoma in 1986. She completed her residency at the University of Oklahoma Children's Hospital. Dr. Brehm specializes in pediatrics.

❖ **Karmel L. Carothers, MD,** Suite 709, 1515 W. Truman Rd., Independence, MO 64050, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Carothers received her medical degree at the University of Kansas in 1990. She completed her residency at the Medical College of Wisconsin Affiliated Hospitals. Dr. Carothers specializes in internal medicine.

❖ **David S. Cochran, MD,** 3231 S. National Ave., Springfield, MO 65807, has become a member of the Greene County Medical Society. Dr. Cochran received his medical degree at the University of Kansas in 1986. He completed his residency at Baylor College of Medicine Affiliated Hospitals, Houston, TX. Dr. Cochran specializes in cardiology.

❖ **Janet Cranshaw, MD,** 226 S. Woods Mill Rd., Chesterfield, MO 63017, has become a member of the St. Louis Metropolitan Medical Society. Dr. Cranshaw received her medical degree at Washington University in 1988. She completed her residency at Cardinal Glennon Children's Hospital. Dr. Cranshaw specializes in pediatrics.

❖ **Kenneth A. DeCoursey, MD,** 211 St. Francis, Cape Girardeau, MO 63701, has become a member of the Cape Girardeau County Area Medical Society. Dr. DeCoursey received his medical degree at the University of Mississippi in 1980. He completed his residency at st. Francis Hospital, Memphis, TN. Dr. DeCoursey specializes in emergency medicine.

❖ **Marcus A. Desio, MD,** 2817 McClelland #213, Joplin, MO 64804, has become a member of the Jasper County Medical Society. Dr. Desio received his medical degree at Cebu Doctor's College of Medicine, Philippines in 1984. He completed his residency at St. Francis Hospital, Springfield, IL. Dr. Desio specializes in neurology.

❖ **Douglas W. Ditzel, DO,** P.O. Box 2787, 2727 McClelland Blvd., Joplin, MO 64803, has become a member of the Jasper County Medical Society. Dr. Ditzel received his doctor of osteopathy at the Chicago College of Osteopathic Medicine in 1983. He completed his residency at the University of Texas Health Science Center, San Antonio. Dr. Ditzel specializes in radiation oncology.

❖ **Robert E. Fast, MD,** 1502 N. 36th St., St. Joseph, MO 64506, has become a member of the Buchanan County Medical Society. Dr. Fast received his medical degree at the University of Kansas in 1974. He completed his residency at the University of Kansas Medical Center. Dr. Fast specializes in obstetrics/gynecology.

❖ **Mary R. Forman, MD,** Suite 440, 6675 Holmes, Kansas City, MO 64131, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Forman received her degree at Rush Medical College, Chicago in

1980. She completed her residency at University of Rochester Medical Center. Dr. Forman specializes in internal medicine.

❖ **Jeffrey A. Greenberg, MD,** 1020 McIntosh Circle, Joplin, MO 64804, has become a member of the Jasper County Medical Society. Dr. Greenberg received his medical degree at the Medical University of South Carolina in 1978. He completed his residency at Georgetown University Hospital. Dr. Greenberg specializes in neurological surgery.

❖ **Mark H. Gregory, MD,** 8000 Bonhomme, Clayton, MO 63105, has become a member of the St. Louis Metropolitan Medical Society. Dr. Gregory received his medical degree at the University of Vermont in 1986. He completed his residency at Rush Medical Center, Oak Park, IL. Dr. Gregory specializes in internal medicine.

❖ **Kenneth C. Huber, MD,** Suite 2000, 4330 Wornall Rd., Kansas City, MO 64111, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Huber received his medical degree at St. Louis University in 1985. He completed his residency at the Mayo Medical School. Dr. Huber specicalizes in internal medicine.

❖ **Dale E. Jarka, MD,** 2401 Gillham Rd., Kansas City, MO 64108, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Jarka received her medical degree at McGill University, Montreal, Quebec, Canada, in 1983. She completed her residency at McGill University. Dr. Jarka specializes in pediatric orthopedics.

❖ **Linda L. Johnson, MD,** Blue 3, 2411 Holmes, Kansas City, MO 64108, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Johnson received her medical degree at the University of Missouri-Kansas City in 1987. She completed her residency at the Cleveland Clinic, Cleveland, OH. Dr. Johnson specializes in internal medicine.

❖ **Jace S. Jones, MD,** 1965 S. Fremont, Springfield, MO 65804, has become a member of the Greene County Medical Society. Dr. Jones received his medical degree at the University of Arkansas in 1986. He completed his residency at Vanderbilt University. Dr. Jones specializes in urology.

❖ **James B. Kelly, MD,** #350, 1001 E. 101st Terr., Kansas City, MO 64131, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Kelly received his medical degree at the University of Kansas in 1988. He completed his residency at the University Alabama Hospitals. Dr. Kelly specializes in anesthesiology.

❖ **Ian A. Kling, MD,** 1805 Heritage Hills Center, Washington, MO 63090, has become a member of the Franklin-Gasconade-Warren Medical Society. Dr. Kling received his medical degree at Washington University in 1975. He completed his residency at the Missouri Institute of Psychiatry, St. Louis. Dr. Kling specializes in psychiatry.

❖ **Michael S. Korenfeld, MD,** 211 North Meramec, Clayton, MO 63105, has become a member of the St. Louis Metropolitan Medical Society. Dr. Korenfeld received his medical degree at Washington University in 1986. He completed his residency at the University of Missouri-Columbia. Dr. Korenfeld specializes in ophthalmology.

❖ **Donald P. Kratz, MD,** 1900 S. National, Ste 2960, Springfield, MO 65804, has become a member of the Greene County Medical Society. Dr. Kratz received his medical degree at the University of Kansas in 1988. He completed his residency at HCA Wesley, Wichita, KS. Dr. Kratz specializes in obstetrics/gynecology.

❖ **Jerry L. Laster, MD,** 1020 McIntosh Circle, Joplin, MO 64804, has become a member of the Jasper County Medical Society. Dr. Laster received his medical degree at the University of Texas Southwestern Medical School in 1984. He completed his residency at the University of Missouri-Columbia Hospital and Clinics. Dr. Laster specializes in general surgery.

❖ **Lawrence M. Mayer, MD,** 30 Doctors Park, Cape Girardeau, MO 63701, has become a member of the Cape Girardeau County Area Medical Society. Dr. Mayer received his medical degree at the University of Illinois in 1969. He completed his residency at Illinois Masonic Hospital, Chicago. Dr. Mayer specializes in anesthesiology.

❖ **Victor E. Mejia, MD,** 1012 N. Main, P.O. Box 1068, Sikeston, MO 63801, has become a member of the Southeast Missouri Medical Society. Dr. Mejia received his medical degree at the Universidad Central Caribe Cayey Medical School, Puerto Rico, in 1981. He completed his residency at Providence Hospital, Southfield, MI. Dr. Mejia specializes in internal medicine.

❖ **Suzanne L. Miller, MD,** 8025 Dale Ave., St. Louis, MO 63038, has become a member of the St. Louis Metropolitan Medical Society. Dr. Miller received her medical degree at the University of Illinois in 1978. She completed her residency at St. Louis Children's Hospital. Dr. Miller specializes in pediatrics.

❖ **Julie A. Moore, MD,** Suite 310, 205 West R.D. Mize Rd., Blue Springs, MO 64014, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Moore received her medical degree at the University of Missouri-Kansas City in 1986. She completed her residency at St. Luke's Hospital. Dr. Moore specializes in obstetrics/gynecology.

❖ **Hooshang H. Nadershahi, MD,** P.O. Box 410441, St. Louis, MO 63141, has become a member of the Missouri State Medical Association. Dr. Nadershahi received his medical degree at Tabriz Medical School, Tabriz, Iran, in 1966. He completed his residency at Columbia University, Columbia, MO. Dr. Nadershahi specializes in psychiatry.

❖ **Michael J. Nelson, MD,** I-35 & Armour Road East, North Kansas City, MO 64114, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Nelson received his medical degree at the University of Illinois in 1989. He specializes in emergency medicine.

❖ **Jeffrey A. Parres, MD,** 456 N. New Ballas, Suite 348, St. Louis, MO 63141, has become a member of the St. Louis Metropolitan Medical Society. Dr. Parres received his medical degree at the University of Missouri-Columbia in 1987. He completed his residency at the Medical College of Ohio. Dr. Parres specializes in urology.

❖ **Philip G. Pettett, MD,** 2401 Gillham Rd, Kansas City, MO 64108, has become a member of the Missouri State Medical Association. Dr. Pettett received his medical degree at the University of Indiana in 1971. He completed his residency at Fitzsimons Army Medical Center, Aurora, CO. Dr. Pettett specializes in pediatrics and neonatology.

❖ **Ronley H. Plous, MD,** 1000 Carondelet Dr., Kansas City, MO 64114, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Plous received his medical degree at Wayne State University, Detroit, MI, in 1987. He completed his residency at Mount Sinai Hospital, New York. Dr. Plous specializes in pathology.

❖ **David A. Poggemeier, MD,** 1817 Elm St., St. Charles, MO 63301, has become a member of the St. Charles-Lincoln County Medical Society. Dr. Poggemeier received his medical degree at the University of Missouri-Columbia in 1984. He completed his residency at St. John's Hospital, Springfield, IL. Dr. Poggemeier specializes in emergency medicine.

❖ **Mark D. Rhoads, DO,** 2617 Cummings, Suite B, Joplin, MO 64804, has become a member of the Jasper County Medical Society. Dr. Rhoads received his doctor of osteopathy at the University of Health Science College of Osteopathic Medicine in 1988. He completed his residency at the University of Maryland. Dr. Rhoads specializes in anesthesiology.

❖ **Peter E. Shapiro, MD,** 6724 Troost #200, Kansas City, MO 64131, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Shapiro received his degree at the University of Missouri-Columbia in 1987. He completed his residency at the University of Missouri-Columbia Hospital and Clinics. Dr. Shapiro specializes in otolaryngology, head & neck surgery.

❖ **Glenn K. Shopper, MD,** #350, 1001 E. 101st Terr., Kansas City, MO 64131, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Shopper received his medical degree at Washington University in 1988. He completed his residency at Brigham and Women's Hospital, Boston, MA. Dr. Shopper specializes in anesthesiology.

❖ **John A. Simpson, MD,** 4061 Lindell Blvd., St. Louis, MO 63108, has become a member of the Missouri State Medical Association. Dr. Simpson received his medical degree at Georgetown University in 1960. He completed his residency at Yale New Haven Hospital, New Haven, CT. Dr. Simpson specializes in internal medicine.

❖ **Henry H. Stonnington, MD,** 2R01 Rusk Rehabilitation Center, 1 Hospital Drive, Columbia, MO 65212, has become a member of the Boone County Medical Society. Dr. Stonnington received his medical degree at the University of Melbourne, Victoria, Australia, in 1950. He completed his residency at the Mayo Clinic. Dr. Stonnington specializes in physical medicine and rehabilitation.

❖ **Diane L. Switzner, MD,** 1124 E. University St., Springfield, MO 65807, has become a member of the Greene County Medical Society. Dr. Switzner received her medical degree at the University of Missouri-Columbia in 1984. She completed her residency at Valley Medical Center, Fresno, CA. Dr. Switzner specializes in general surgery.

❖ **Mary J. Valverde-Mejia, MD,** 1012 N. Main, Sikeston, MO 63801, has become a member of the Southeast Missouri Medical Society. Dr. Valverde-Mejia received her medical degree at the University of Puerto Rico School of Medicine in 1984. She completed her residency at Providence Hospital, Southfield, MI. Dr. Valverde-Mejia specializes in internal medicine.

❖ **Gail E. Waldby, MD,** 701 East First St., Trenton, MO 64683, has become a member of the Grand River Medical Society. Dr. Waldby received her medical degree at the University of Kansas in 1977. She completed her residency at the University of Kansas. Dr. Waldby specializes in general surgery.

❖ **Bobby W. Webster, MD,** #100, 10600 Quivira, Overland Park, KS, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Webster received his medical degree at the University of Texas Medical Branch at Galveston in 1974. He completed his residency at HCA Wesley, Wichita, KS. Dr. Webster specializes in obstetrics/gynecology and reproductive endocrinology.

❖ **Marc M. Whitacre, MD,** 8901 W. 74th St., Shawnee Mission, KS 66204, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr.

Whitacre received his medical degree at the University of Pennsylvania in 1979. He completed his residency at the University of Colorado. Dr. Whitacre specializes in ophthalmology.

❖ **Susan E. Winkelmann, MD,** N607, 1 Hospital Drive, Columbia, MO 65212, has become a member of the Boone County Medical Society. Dr. Winkelmann received her medical degree at the University of Missouri-Columbia in 1984. She completed her residency at the University of Missouri-Columbia. Dr. Winkelmann specializes in obstetrics/gynecology.

RESIDENTS

Martin M. Anbari, MD - *Radiology*
Gregory M. Bazell, MD - *General Surgery*
Richard L. Butler, MD - *Nuclear Medicine*
Lucky A. Chopra, MD - *Radiology*
Steven W. Cummings, MD - *Internal Medicine*
Mitchell N. Faddis, MD - *Internal Medicine*
Melissa A. Frame, MD - *Internal Medicine*
William H. Fritz, MD - *Internal Medicine*
Lisa K. Hinckley, MD - *Diagnostic Radiology*
S. Jessy Lorion, MD - *Family Practice*
Stanley B. Martin, MD - *Neurosurgery*
Nancy K. Palis, MD - *Internal Medicine*
Patrick T. Rucker, MD - *Diagnostic Radiology*
Brian A. Smart, MD - *Pediatrics*
Mark W. Smith, MD - *Urology*
Steven J. Stokesbary, MD - *Orthopedics*

STUDENTS

University of Missouri-Columbia

Belinda R. Fender
Nancy C. Mabe

University of Missouri-Kansas City

Brian C. Brauer
Amina B. Chapin
Lance F. Grenevicki
Seong Keun Lee
Clifford Liu
Robin Morris

St. Louis University

Eric Aspinwall

Washington University

Brenda Brischetto

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CME CALENDAR

The continuing medical education accreditation program of the MSMA has full approval by the AMA's Council on Medical Education. The institutions and functions listed here qualify for Category I credit for the AMA Physician's Recognition Award. All accredited institutions in Missouri are invited to send CME information for listing in *MISSOURI MEDICINE*. Please remember to include the name of the individual who can be contacted at your institution for additional information about your CME events.

September

10 - *St. Louis*: John V. King Family Medicine Symposium. Contact St. John's Mercy Medical Center, 314/569-6290.

10 - *Springfield*: ACLS Recertification Course. 8 credit hours. Call Donna Willoughby, Cox South, 417/885-4117.

10 to 12 - *St. Louis*: Frontiers in Endosurgery: Advances in Endourological Techniques and Technology. 18.5 credit hours. Contact CME, Washington University, 314/362-6893 in MO or 800/325-9862 interstate.

10 - *Kansas City:* Primary Care. 6 credit hours. Contact The Ed Bixby Institute for Postgraduate Medical Education, Research Medical Center, in MO 800/892-5771, ext 4306, bordering states 800/ 821-5140, ext 4306.

10 to 12 - *Washington, DC*: Primary Care Update and Board Review. 20 credit hours. Contact Maria Gorrick, George Wasington University Medical Center, CME, 202/994-4285.

11 - *Chesterfield*: Macular Degeneration: Beyond the Macular Photocoagulation Study. 3 credit hours. Contact Carol Broemmer, St. Luke's Hospital, 314/542-4759.

11 to 14 - *Washington, DC*: The Decade of the Brain: An International Conference. 28 credit hours. Contact John F. Vargo, George Washington University, CME, 202/994-4285.

14 - *Chesterfield*: St. Luke's 1993 Clinical Update III, Trends in Orthopedic Surgery. 1.5 credit hours. Contact Carol Broemmer, St. Luke's Hospital, 314/542-4759.

15 to 17 - *Kansas City*: Complex Coronary Angioplasty and New Interventional Devices. 20 credit hours. Contact Beth M. Paul, 816/932-2301. Registration deadline 8/15/93.

16 to 18 - *Kansas City*: Minority Health Care Issues. Contact Barry Kling, MU-Columbia, CME, 314/882-4105.

17 & 18 - *St. Louis*: Physician Executive Leadership. Contact the Office of CME, Washington University, 314/362-6893 or 800/325-9862.

17 to 19 - *St. Louis*: Practical Anatomy and Surgical Technique Workshop: Microsurgery of the Lumbar and Cervical Spine. 20 credit hours. Contact the St. Louis University, CME, 314/577-8167 or 800/553-2712.

18 - *St. Louis*: Gastroenterology/Hepatology Update. Contact the St. Louis University, 314/577-8167 or 800/553-2712.

18 - *Chesterfield*: Suicide and Clinical Practice: An Update for Healthcare Professionals. Contact CME, Washington University, 314/362-6893 in MO or 800/325-9862 interstate.

18 to 19 - *Columbia*: 3rd Annual Caring for the Frail and Elderly. Contact Barry Kling, MU, CME, 314/882-4105.

20 - *St. Louis*: City-Wide Radiology Conference: Richard Semelka, III, MD - MRI: New Approaches for Diagnosing Abdominal Disease. Contact R. Gilbert Jost, MD, Chief of Diagnostic Radiology, Mallinckrodt Institute of Radiology, 314/362-7130.

22 - *St. Louis*: 6th Annual Trauma Care Conference. 6.5 credit hours. Contact St. John's Mercy Medical Center, 314/569-6290.

20 to 22 - *St. Louis*: Practical Anatomy and Surgical Technique Workshop: Advanced Applications in Endoscopic Neurosurgery. 14 credit hours. Contact the St. Louis University, CME, 314/577-8167 or 800/553-2712.

20 to 22 - *St. Louis*: Pediatric Advanced Cardiac and Trauma Support for Life/Pediatric Advanced Life Support Provider Course. 20 credit hours. Contact Mary Beth Foerstel, St. Louis University, CME Office, 314/577-8167.

23 - *Marina Del Rey, CA*: Frontiers in Ovulation Induction. Contact CME, Washington University, 314/362-6893 in MO or 800/325-9862 interstate.

23 & 24 - *St. Louis*: Practical Anatomy and Surgical Technique Workshop - Advanced Applications in Endoscopic Neurosurgery. 14 credit hours. Contact St. Louis University, CME, 314/577-8167 or 800/553-2712.

24 & 25 - *Kansas City*: Management of Cardiac Emergencies. 13 credit hours. Contact Kim Dwork, St. Luke's Hospital of Kansas City, 816/932-5140.

26 - *St. Louis*: Modern Keratorefractive Surgery: A Safe, Comprehensive Approach to Radial and Astigmatic Keratotomy. 7 credit hours. Contact Dr. Assil, St. Louis University, 577-8264.

28 & 29 - *St. Louis*: Fourth Annual Spinal Cord Symposium. 13 credit hours. Contact Dorthy Bohning, R.N., St. Louis University, 577-8920.

29 - *St. Louis*: Electroconvulsive Therapy an Educational Course. 7 credit hours. Contact St. Louis University, CME, 314/577-8167 or 800/553-2712.

30 - *St. Louis*: Creating the Healing Community. 5 credit hours. Contact Liz Hogan, St. Louis University, 577-8195.

October

1 - *St. Louis*: 4th Annual Ultrasound Symposium. Contact St. John's Mercy Medical Center, 314/569-6290.

1 & 2 - *St. Louis*: Update in Diabetes and Endocrinology. 11 credit hours. Contact St. Louis University, CME, 314/577-8167 or 800/553-2712.

1 & 2 - *St. Louis*: Physician Executive Leadership. Contact CME, Washington University, 314/362-6893 in MO or 800/325-9862 interstate.

1 to 3 - *Arlington, VA*: International Liver Symposium. 14 credit hours. Contact Hattie Johnson, George Washington University, CME, 202/994-4285.

2 & 3 - *Springfield*: Pediatric Advanced Life Support (PALS). 16 credit hours. Call Lisa McFall, 417/885-5400.

4 to 8 - *St. Louis*: Medicolegal Death Investigator Training Course. 33 credit hours. Contact Mary Fran Ernst, St. Louis University, 314/522-6410, ext. 6509.

6 to 14 - *Belgium*: Allergy Abroad: Holland and Brussels. 17 credit hours. Contact CME, Washington University, 314/362-6893 in Mo or 800/325-9862 interstate.

7 - *Chesterfield*: Oncology Update: Management of Prostate Cancer. 2 credit hours. Contact Carol Broemmer, St. Luke's Hospital, 314/542-4759.

7 & 8 - *Kansas City*: Basic & Advanced Fetal Heart Rate Monitoring Seminars. 12 credit hours. Contact Carol Osborne, CME Office, Saint Luke's Hospital of K. C., 816/932-3737.

8 & 9 - *St. Louis*: Advanced Trauma Life Support Course. 16 credit hours. Contact Mary Keegan, R.N., St. Louis University, 314/577-8365.

8 & 9 - *Springfield*: Pediatric Advanced Life Support Provider Course. 17 credit hours. Call Cox South, 417/885-6111.

8 & 9 - *Walt Disney World Dolphin Hotel, Orlando, FL*: Workshop on Stress Echocardiography. 13 credit hours. Contact Beth Paul, St. Luke's Hospital of K. C., 816/932-2301.

9 - *St. Louis*: Modern Keratorefractive Surgery: A Safe, Comprehensive Approach to Radial and Astigmatic Keratotomy. 7 credit hours. Contact Dr. Assil, St. Louis University, 314/577-8264.

9 to 13 - *Arlington, VA*: Gastroenterology Board Review Course. 42 credit hours. Contact Daniel E. Reichard, George Washington University, CME, 202/994-4285.

9 to 13 - *Penatgon City, VA*: Medical Oncology Board Review Course. 38 credit hours. Contact John F. Vargo, George Washington University, 202/994-1791.

11 - *St. Louis*: Wendell G. Scott Lecture: C. Douglas Maynard, MD - A Challenge to Radiologists: The Changing World of Accreditation and Certification. 2 credit hours. Contact Ronald G. Evens, MD, Director, Mallinckrodt Institute of Radiology. 314/362-7100.

11 to 13 - *St. Louis*: Midas Rex Institute Hands-On Workshop. Contact Midas Rex Institute, 800/433-7639.

12 & 13 - *St. Louis*: Transesophageal Echocardiography Course. 13 credit hours. Contact Dianne Reid, St. Louis University, 314/577-8897.

13 - *St. Louis*: Controversies in Women's Health Care. 6 credit hours. Contact St. Louis University, CME office, 314/577-8167 or 800/553-2712.

14 to 16 - *St. Louis*: Practical Anatomy & Surgical Technique Workshop: Surgical Approaches to the Skull Base. 24 credit hours. Contact St. Louis University, CME, 314/577-8167 or 800/553-2712.

15 - *Kansas City*: Infection Control: Taking Care of the Health Care Worker. 6 credit hours. Contact The Ed Bixby Institute, 816/756-1500, in MO 800/892-5771, ext 4306, bordering states 800/ 821-5140, ext 4306.

15 - *Chesterfield*: The St. Luke's Cleft Palate Team Approach to the Management of Speech and Hearing Disorders. 6 credit hours. Contact Carol Broemmer, St. Luke's Hospital, 314/542-4759.

16 - *St. Louis*: 2nd Annual Midwest Clinical Molecular Cardiology Conference. Contact St. Louis University School of Medicine, CME office, 314/577-8167 or 800/553-2712.

20 - *St. Louis*: Pediatric Advanced Cardiac and Trauma Support for Life/Pediatric Advanced Life Support Recertification Course. 7 credit hours. Contact Mary Beth Foerstel, St. Louis University, CME Office, 314/577-5385.

21 & 22 - *Lake of the Ozarks, Tan-Tar-A*: 12th Annual Missouri Conference on Genetic Disorders. Contact Karen Rhodes, Missouri Institute of Mental Health, 314/644-8803.

22 - *Springfield*: ACLS Recertification Course. 8 credit hours. Call Donna Willoughby, Cox South, 417/885-4117.

22 & 23 - *Chesterfield*: 7th Annual Symposium and Workshop on Gynecologic Endoscopy: Advances, Complications and Controversies. 12.5 credit hours. Contact Carol Broemmer, St. Luke's Hospital, 314/542-4759.

23 - *St. Louis*: A Practical Approach to Prevention. Contact St. Louis University, CME, 314/577-8167 or 800/553-2712.

24 to 27 - *Raleigh/Durham, NC*: 15th Annual Society for Medical Decision Making Meeting. 21 credit hours. Contact Maria Gorrick, 202/994-8929.

29 - *Teaneck, NJ*: Frontiers in Ovulation Induction. Contact CME, Washington University, 314/362-6893 in MO or 800/325-9862 interstate.

November

3 - *St. Louis*: Updates in Psychiatry/Psychotherapy. 3.5 credit hours. Contact St. John's Mercy Med. Center, 314/569-6290.

4 to 6 - *Kansas City*: Kansas City Southwest Clinical Society's 71st Annual Fall Clinical Conference. Contact Linda F. Smutz, 816/523-3383.

5 & 6 - *St. Louis*: Allergy Update. Contact St. Louis University, CME office, 314/577-8167 or 800/553-2712.

8 to 10 - *St. Louis*: Practical Anatomy and Surgical Technique Workshop - Approaches to Cranio-Cervical Fixation. Contact St. Louis University, CME, 314/577-8167 or 800/553-2712.

8 - *St. Louis*: City-Wide Radiology Conference: John V. Crues, MD - MRI of the Shoulder. Contact R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology, 314/362-7130.

10 to 12 - *St. Louis*: Pediatric Advanced Cardiac and Trauma Support for Life/Pediatric Advanced Life Support Provider Course. 20 credit hours. Contact Mary Beth Foerstel, St. Louis University, CME Office, 314/577-5385.

11 to 14 - *St. Louis*: Anesthesiology & The Geriatric Patient. Contact CME, Washington University 314/362-6893 in MO or 800/325-9862 interstate.

12 & 13 - *St. Louis*: Practical Anatomy and Surgical Technique Workshop - Advanced Applications in Endoscopic Neurosurgery. 14 credit hours. Contact St. Louis University, CME office, 314/577-8167 or 800/553-2712.

12 & 13 - *Washington, DC*: Interdisciplinary Approach to the Diagnosis and Management of Endocrine Disorders. 13.5 credit hours. Contact Daniel E. Reichard, George Washington University, CME, 202/994-4285.

12 & 13 - *St. Louis*: Head & Neck Oncology. Contact CME, Washington University 314/362-6893 in MO or 800/325-9862.

12 to 14 - *Big Cedar Lodge, Branson*: MAFP Fall CME Conference. 10 credit hours. Over 20 possible CME hours offered. Contact MAFP, 816/747-5114.

12 to 14 - *St. Louis*: 20th Annual Anesthesia and the Geriatric Patient. 16.25 credit hours. Contact CME, Washington University 314/362-6893 in MO or 800/325-9862 interstate.

13 - *Columbia*: 7th Annual Obstetrics & Gynecology Update. Contact Barry Kling, MU, 314/882-4105.

16 to 18 - *St. Louis*: Doppler Echocardiography Course. 20 credit hours. Contact Dianne Reid, St. Louis University, 314/577-8897.

17 to 19 - *St. Louis*: Contemporary Cardiothoracic Surgery. 21.5 credit hours. Contact CME, Washington University 314/362-6893 in MO or 800/325-9862 interstate.

19 & 20 - *St. Louis*: 21st Annual Kilo Diabetes Symposium: Current Topics in Diabetes & Vascular Disease. 13 credit hours. Contact Jackie Dudley, R.N., Kilo Diabetes & Vascular Research Foundation, 314/434-6500.

20 - *St. Louis*: Hypercholesterolemia Seminar. Contact CME, Washington University, 314/362-6893 in MO or 800/325-9862.

29 to Dec. 1 - *Springfield*: Advanced Life Support Provider Course. 22.5 credit hours. Call Linda Climer, St. John's Regional Health Center, 417/885-2648.

Physicians Wanted

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INFORMATION FOR CONTRIBUTORS

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Manuscripts should be submitted to the editor, **J. Regan Thomas, MD,** P.O. Box 1028, 113 Madison, Jefferson City, MO 65102. The transmittal letter should designate one author as correspondent and include his or her address and telephone number.

In addition, in view of The Copyright Revision Act of 1976, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: **"In consideration of the Missouri State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA."** We regret that transmittal letters not containing the foregoing language signed by all authors of the submission will necessitate delay in review of the manuscript. Please include the title of the article in the transmittal letter.

Manuscripts

Manuscripts should be typewritten, double-spaced, and the original with one copy submitted. Retain another copy for proofreading. Please number the pages of your manuscript. Manuscripts are not returned. Hospital and University appointments of the author(s) should accompany the manuscript. A synopsis-abstract of no more than 75 words should accompany the manuscript. Manuscripts may be submitted on floppy disks or diskette using WordPerfect 5.1 or other compatible wordprocessing.

References

References should be cited in numerical order in the text and arranged at the end of the article in the same order in which they are cited. The reference should give name of author, title of article, name of periodical, volume number, initial page number and year. Authors are responsible for reference accuracy.

Illustrations

Illustrations should be glossy prints or drawings in India ink on white paper. They should not be mounted and name of author and figure number should be penciled lightly on the back. Legends should appear on a separate sheet. Printing illustrations in one color (black) is standard. Color may be requested with additional cost being the responsibility of the author.

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Reprints

Reprint order blanks will accompany proof, and will be sent to authors prior to publication.

Editorials

Editorials should be written in clear, concise language. Length should be about two or three pages typed with double spacing. Letters will be published at the discretion of the editor, managing editor, and Editorial Board.

Deadlines

All material other than scientific should be received prior to the first of the month preceding month of publication.

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Ron Richmond, MD, joined the CompHealth locum tenens medical staff when he completed his residency. He wanted to travel. He loves to meet people. A little time off sounded really good. And he thinks being exposed to different types of medical practice will serve him well when he returns to his hometown to establish a community health center.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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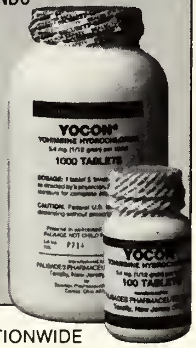

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Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991,14:146-151.

PRAVACHOL® (Pravastatin Sodium Tablets)

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SO 31,906). A small increase was seen in mean AUC values and half-life (t1/2) for the inactive enzymatic ring hydroxylation metabolite (SO 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin. In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SO 31,906 and SO 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SO 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin*, *antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine*, *nicotinic acid*, or *probucol*, no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*, a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells, and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter^2). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated, adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy, this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below, also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug.

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions. An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma, anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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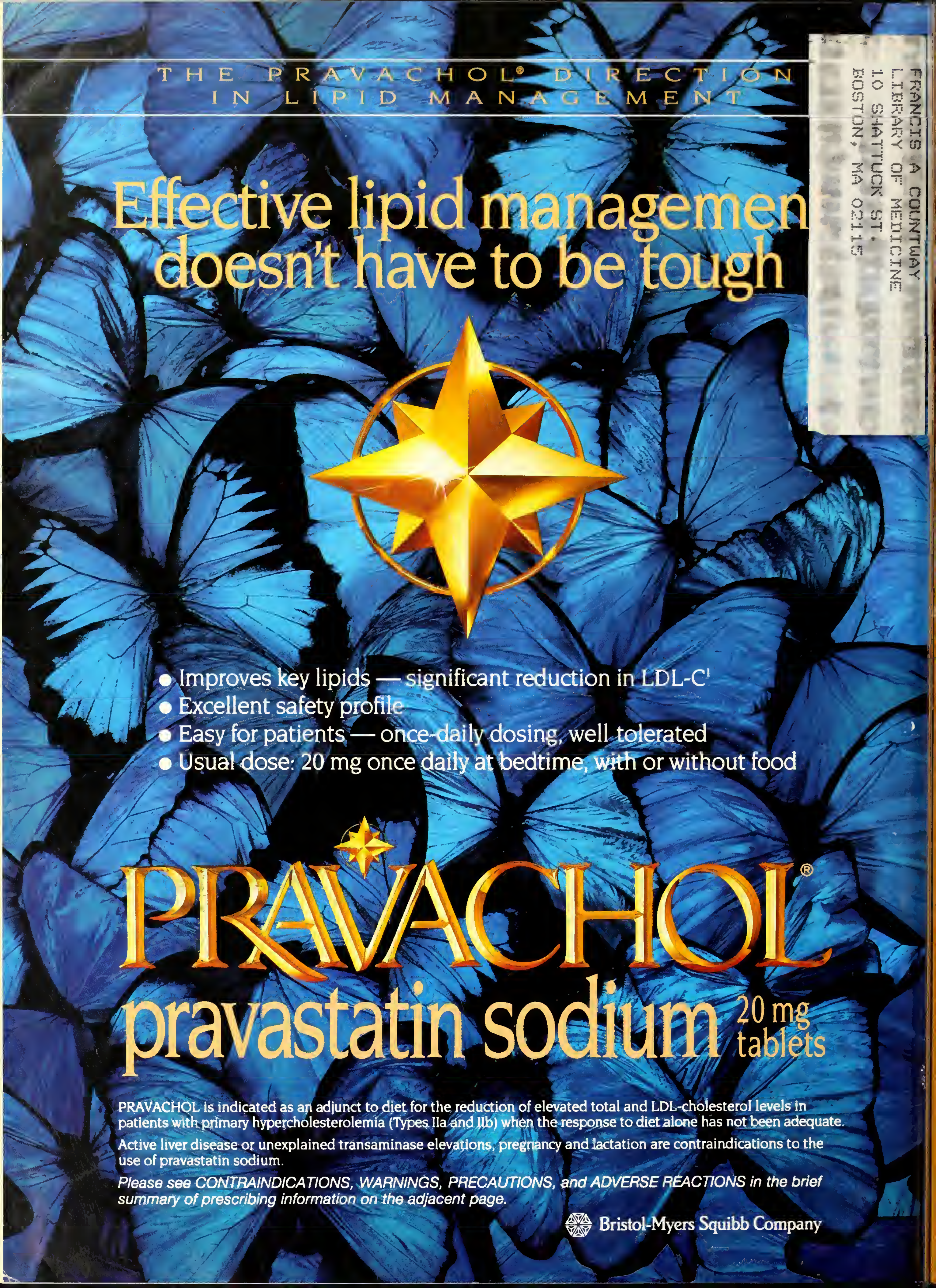

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Effective lipid management doesn't have to be tough
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PRAVACHOL is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate.

Active liver disease or unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of pravastatin sodium.

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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Missouri Medicine

Journal of the Missouri State Medical Association

OCT 6 1993

October 1993

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October Cover

This photograph of Autumn leaves was taken by Kailash Tarnega, MD, a radiologist practicing at the Ozark Medical Center in West Plains, Missouri. This is the fifth *Missouri Medicine* cover to feature his work. Dr. Tarnega enjoys taking pictures of nature and people.

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VIOLENCE IN AMERICA:

an issue of public health

J. Regan Thomas, MD

Violence in America seems to be an unanswered Public Health problem. For certain demographic groups homicide is now a leading cause of death. The violence affects all segments of American society. Statistics show an eerie irony when comparing normally hazardous situations with typical daily risks on the streets. For example young black males serving in the Gulf War were statistically at greater risk to be shot at home as a civilian than during armed military conflict. Reports of homicides in most metropolitan areas are so frequent that they are no longer front page news and reported almost "matter of factly."

Physicians certainly are not immune to this violent trend. Psychiatrists have traditionally been at risk due to various personality disorders and situations with which they must work. One report stated that 40% of psychiatrists were assaulted during their careers and 50% of psychiatric residents reported assaults.

An alarming rate of violence against other types of physicians has developed in recent years. An Indiana medical school study looking at internal medicine residents showed 16% were assaulted once and 6% assaulted more than once.

Recently a Seattle plastic surgeon was killed by a disgruntled aesthetic surgery patient. An otolaryngologist acquaintance of mine from Ann Arbor, Michigan, was shot in the chest and killed by a patient a few months ago. The patient apparently unhappy that his vertigo episodes were not resolving, brought a gun to the office and shot the physician as he entered the exam room.

Most recently, at least two OB-GYN's were in the headlines following being shot, one fatally. These were not shootings by disgruntled or mentally troubled patients, but rather by people with differing political philosophies. The issue of abortion has always generated strong feelings by both sides of the question. These acts of violence directed at physicians likely serve only to further entrench the two opposing camps.

Attorneys and other professionals are of course encountering similar problems. In the community where I live, court house shootings in the past year have resulted in steps which minimized access to the facility, increased security personnel, and instituted metal detectors. Some emergency rooms have also begun to use metal detectors and most have increased security personnel. A "combat zone" mentality has developed.

Is the next inevitable step a fortified office environment? Metal detectors placed at the reception desk. Patients being "frisked" before disrobing for a physical exam. The X-ray machines being used to examine bags and purses instead of diagnostics. Is the quality of care affected by this new fortification? Certainly the classic patient-physician relationship can not be the same as we are draw closer to this scenario.

It is typically dismissed as "reflective of the society in general" when this topic is discussed. Perhaps that is so, but it has invaded one of the more precious of our society's liaisons, the physician's office. If we are simply part of a societal trend of increasing violence, then let us be the catalyst to stop that trend and reverse it. Violence is indeed a public health issue. As in most other public health issues the physician should take a leadership role in addressing the problem.

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MONETAMED PROFILE

THOMAS P. DOYLE, M.D.

HOME: St. Louis, Missouri

AGE: 36.

SPECIALTY: Orthopedic Surgery.

MEDICAL COLLEGE: University of Missouri, 1978

PRACTICE: "I recently purchased an established but declining sole practitioner office from a retiring physician. It's a risk, but they say that great deeds are usually wrought at great risk."

HOBBIES: Horseback riding and golf. "If I combined activities, would it be polo?"

LAST BOOK READ: Missouri: Images of Nature, photographed by Charles Gurche.

LATEST ACCOMPLISHMENT: "Testing a protective knee pad I'm developing for use by football players."

PROFILE: Independent and open-minded. "Living in the country, I don't feel hampered by social convention. I can work on new ways of doing things."

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Let's not have a medical Chernobyl

Melvin C. Kasten, MD, MSMA President

Reports of nuclear accidents around the world seem to be appearing more frequently. Chernobyl's 1986 nuclear accident, covered well in Piers Paul Read's book, *Ablaze*, is one example.

Today, I noticed a newspaper article that reported another atomic reactor accident. This more recent disaster occurred in North Korea and, according to a defector who reported on the incident, it killed hundreds.

Final details remain vague, however, because North Korea is controlled by a highly centralized government and, like the USSR in 1986, its leaders are loath to admit that their policies might have been responsible for such a calamity.

Once exposed, Chernobyl sped the breakup of the Communist confederation but, it took several years before accurate information about the tragedy could trickle out to the free world. These reports give us several things to think about. First is the inherent difficulties of harnessing massive power to do good for the public, while controlling its potential for unleashing equally large amounts of damage and destruction upon the very people it is supposed to serve. Those of us who live near the Mississippi or Missouri can speak first hand about this paradox.

Next, we might consider the average politician's almost instinctive reluctance to accept any culpability when damage or tragedy follows in the wake of ill-conceived policies. An eager army of bureaucrats enforces the law, even if it means forcibly removing a two-year baby from the only home she has known.

I think we can learn from such technological and human catastrophes. And, we can apply this wisdom as we watch our political leaders overhaul healthcare policies in the 1990s.

As physicians, we can help our fellow citizens realize that, in essence, every pill that's prescribed has a contraindicated warning. If you misuse it or mix it with other drugs, a pill intended to relieve pain and suffering suddenly can become a concoction that does more harm than good. We physicians should express to as many people who will listen that this rule holds true for policy decisions regarding government supervised healthcare, too.

Delivering healthcare to millions of people requires intricate, multifaceted, and compassionate policy decisions. As our politicians decide how best to provide medical care to all citizens, we must strongly assert that some of their decisions should be dispensed with the contraindicated warnings clearly labeled.

If we saw a radical treatment being advertised to our patients as having no side effects - take a dose of any strength, as frequently as you like - we'd be up in arms to warn our patients. We have the same responsibility when we hear the "pie-in-the-sky" pronouncements about healthcare "cures" that will come spinning out of Washington in the next few months.

Part of Chernobyl's tragedy was that both the unsuspecting people and those who should have known better put their trust in a faulty technology. A larger tragedy however is that a large number of people put their faith in public policies that were created in a vacuum.

Moscow's policy makers disregarded their expert advisors and proclaimed their nuclear program to be perfect, the equal to anything the West could develop. Accordingly, the only acceptable reasons for any malfunction had to be either incompetence or sabotage.

In the investigation and "show" trials that followed Chernobyl, Moscow was puzzled to find that neither incompetent workers nor saboteurs were to blame. The courts sentenced several of the plant's supervisors to long prison terms just in case, even though these individual had risked exposure to massive dosages of radiation to stay at their posts

Continued on page 638

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Continued from page 637

and surely saved thousands of lives through their heroic actions. Acquiescence to orders that proved to be stupid after the fact was not an acceptable defense.

Meanwhile, here at home, let's listen closely to our government and the media reports as descriptions of the healthcare reform policy emerge. The "contraindications" of that policy need to be set forth as part of the plan.

Get ready to protest loudly when and if our policy makers claim they've created a painless cure that will fix everybody's problems and save money to boot. That sort of speech will sound good on the floor of Congress and be widely touted on talk radio and other friendly media outlets. But, once the bureaucrats sell a "perfect" healthcare plan to the American people, the inevitable malfunctions will be laid at the healthcare provider's doorstep.

Since the plan is perfect, the bureaucrats will tell patients, if they are not being served properly the doctors must be incompetent or, heaven's forbid, saboteurs. When that happens, we'll find that our obedience to a flawed policy will not go unpunished either. ■

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Protect Your Right to Complain

Nona Nan Chapman, Vice President-Legislation

"You forfeit the right to complain if you're not willing to work and take part of the blame." -- **Mary C. Kasten, 158th District State Representative and wife of MSMA President Dr. Melvin Kasten.**

According to AMA statistics, only 49% of all Missouri's physicians and their spouses are registered to vote.

As Legislative Affairs Chairman for the MSMA Alliance, this quote spurs thoughts in many directions. However, I would like to share with you an important concern of the Missouri State Association Alliance: Voter Registration.

According to AMA statistics, only 49% of all Missouri's physicians and spouses are registered to vote. MSMA Alliance has long been working and encouraging county voter registration drives. Voting is the right and responsibility of all qualified citizens.

The only requirements are that you must be:

- **A U.S. citizen.**
- **At least 18 years of age.**
- **Not convicted of a felony.**
- **A resident of the county and state where registering.**
- **Not declared legally incompetent.**

Anyone desiring to register to vote in the state can do so by visiting your local election authority or you now can register by mail. Call your county clerk's office, or your election board, for registration details. Register by the 4th Wednesday prior to any election in order to vote in that particular election. After registering, you're eligible to vote in any election.

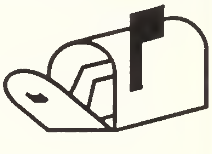
Absentee ballots may be obtained if a person is absent from the county on election day, ill or disabled, has religious beliefs or practices preventing voting in person, is employed by an election authority or is in the armed forces.

Once you've applied for and received the absentee ballot, be sure to fill out all information on the envelope provided. The ballot then must be sent by mail or delivered in person to the election authority.

How then, can those of us who are registered voters be in the minority? Only 1.8% of Missouri's licensed physicians are not U.S. Citizens, which makes Mary's words even more to the point. We should all immediately get to work on our fellow physicians and spouses. Encourage each of them to exercise this precious right of civic duty.

Protect your right to complain. But first, **register**. On election day, go **vote**. Then complain!

Find out about registering by mail!
Contact your county clerk or election board.



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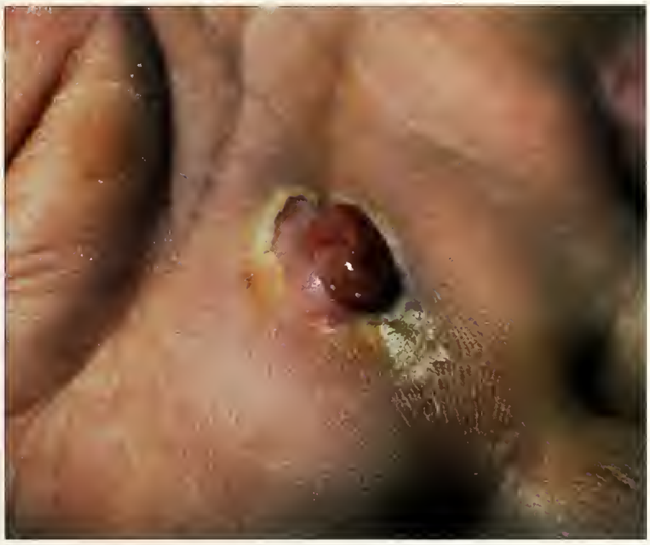
Dermatology Quiz #7



This 54-year-old male presented to your office 3 weeks ago for removal of a wart on the palm of his hand. You treated this with liquid nitrogen cryosurgical destruction.

Two weeks later he calls you to report that although the wart seemed to have gone away following the freezing, that it had suddenly reappeared. The lesion pictured is the new "wart." In about one week the lesion suddenly grew to this size.

1) The single best clinical diagnosis is:

a. Recurrent wart
b. Kaposi's sarcoma
c. Pyogenic granuloma
d. Metastatic cancer

2) The appropriate treatment at this point would be:

a. Re-treat with liquid nitrogen freezing
b. Excise and send for surgical pathology
c. Cauterize with silver nitrate stick
d. Shave biopsy with surgical pathology and destruction of base

3) The prognosis for this patient is:

a. Excellent, with conservative intervention
b. 80% mortality, even with radiation and chemotherapy
c. Curative, with amputation of the hand
d. 25% mortality, with radiation therapy

(See Answers on next page.)

DERMATOLOGY QUIZ ANSWER

(Dermatology Question is on previous page.)

Answers:

1) c - Pyogenic granuloma
2) b - Excise and send for surgical pathology
or d - Shave biopsy with surgical pathology and destruction of base
3) a - Excellent, with conservative intervention.

Pyogenic granuloma is one of those poorly-named dermatologic conditions. The "pyo-" implies that this lesion is generated from a purulent infectious process, which it is not. These lesions are a reactive process, frequently a result of trauma to the skin such as a puncture injury, or non-healing sore. Iatrogenic causes include a destructive procedure (freezing, cautery, curettage, laser) and occasionally a result of medication (isotretinoin treatment of acne).

Individual lesions appear highly vascular, exactly as an hemangioma of abrupt onset. A new lesion is bright red but may darken to brownish-red or blue-black with age. Although soft and moderately compressible, the lesion cannot be completely blanched. Pyogenic granuloma are not pulsatile. Under hand lens magnification the surface is smooth and glistening with a small collarette at the periphery of the base. Most lesions are 5-10 mm in diameter, although rarely a few centimeters. Lesions are commonly found on the hands (especially fingers), feet, lips, head (especially beard area and neck) and upper trunk, as well as the mucosal surfaces of the mouth and perianal areas.

A common oral variant is a vascular ectatic growth of the gingiva, an epulis. These gingival lesions, like other cutaneous vascular ectasia, are particularly common during pregnancy, hence are known as granuloma gravidarum or "pregnancy tumors."

Other clinical variants include multiple satellite nodules, a desseminated form and intradermal and subcutaneous types. During isotretinoin therapy for acne, pyogenic granuloma-like lesions may erupt at the site of each resolving acne cyst. In addition, periungual lesions of either toes or fingers are noted more often during isotretinoin therapy, particularly at the site of ingrown toenails.

The pathology of pyogenic granuloma is just as one would expect: a lobular arrangement of capillaries in a loose, frequently edematous, stroma. The vessels are newly formed capillaries with a single-celled endothelial lining, without atypia. The constricted base (collarette) is often apparent, with a polymorphous inflammatory cell infiltrate.

In the setting of our patient one can reasonably be assured that this is a pyogenic granuloma secondary to the wart treatment. Since one seldom has the luxury of such a classic presentation, surgical pathology is advised. Confusion with other benign lesions is common, such as molluscum contagiosum, capillary hemangiomas, inflamed seborrheic keratosis, viral warts, or glomus tumor. Malignant mimics include angiosarcoma, Kaposi's sarcoma, bacillary angiomatosis, malignant melanoma (especially amelanotic), Spitz nevus ("juvenile melanoma"), and metastatic carcinoma (especially renal cell). As with all neoplasms, the history, distribution of lesions, and lesional morphology are helpful, but cannot replace examination under the microscope for certainty.

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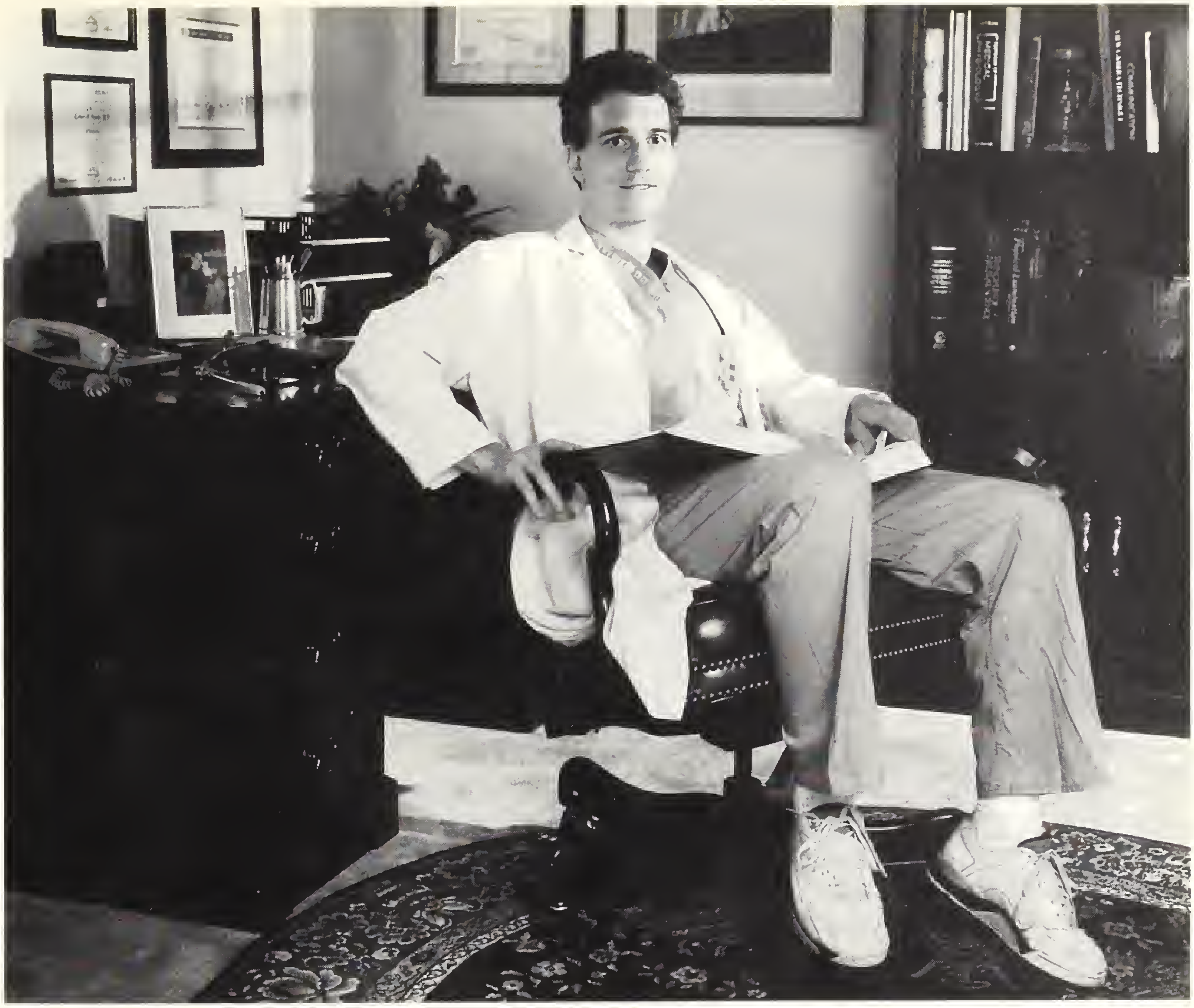
Submitted by Ronald W. Swinfard, MD, Assistant Professor and Chief, Dermatology Section, Harry S. Truman VA Hospital, Columbia, Missouri.

The Dermatology Quiz is coordinated by Philip C. Anderson, MD, Professor and Director at the University of Missouri in the Division of Dermatology.



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The 136th Annual Convention of the Missouri State Medical Association

April 7-10, 1994
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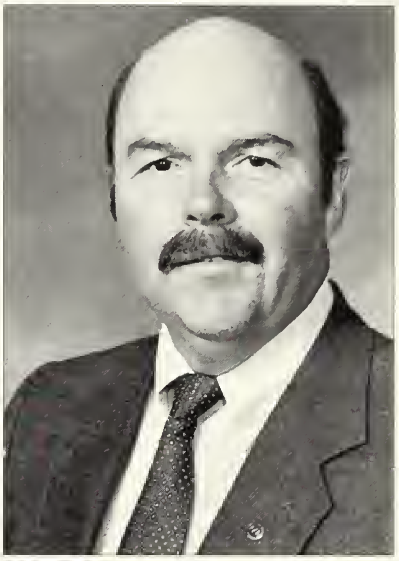

Dr. Jacott

The Missouri State Medical Association's Convention will include a wide variety of scientific sessions, covering over 20 specialties and myriad of topics. This is an outstanding opportunity for members to pick up continuing medical education hours in a convenient forum. Many specialty groups will hold their annual meetings in conjunction with the MSMA Convention.

Our special guest from the AMA will be William E. Jacott, MD, Vice Chair of the AMA Board of Trustees and a member of the Board's Executive Committee. He represents the AMA on the Boards of the Joint Commission on Accreditation of Healthcare Organizations and American Association for the Accreditation of Laboratory Animal Care. He also represents the AMA Board at the Managed Care Partnership. Dr. Jacott is assistant vice president for health sciences at the University of Minnesota, Minneapolis, a position he assumed in 1987 after more than 20 years in private family practice in Duluth, Minnesota. He continues to be involved in teaching and patient care as an associate professor in the University's Department of Family Practice and Community Health. He will address the House of Delegates on Thursday, April 7 and will be a featured speaker at the General Session, Friday, April 8.

The 136th Annual Convention promises to be another fine meeting in the long tradition of the Missouri State Medical Association. We hope to see you in Kansas City.

Dates to Remember

October 5, 1993	**Specialty Program Due in MSMA Office**
January 3, 1994	**Preliminary Program/Hotel Reservation Card Mailings**
January 7, 1994	**Final Program Due in MSMA Office**
January - March 1994	**Delegates Will be Selected**
February 21, 1994	**Resolutions Due in MSMA Office**
March 8, 1994	**Delegate Handbook Mailings**

Handling Patient Complaints

Danielle Halsel

The Problem: THE ANGRY PATIENT

The healthcare marketplace has changed dramatically in the past few years - and for many reasons. Patients and payers are judging the VALUE of medical care according to new standards which place more demands on physicians, administrators, supervisors, and staff members. We live in a "service" society; and people care about the quality of products and services. But they're just as concerned about the way those products and services are delivered.

Patient-expectations are higher than they were in the past, and sometimes not completely attainable; and the "3-11" rule predicts a satisfied patient will tell three people about your practice...while an unhappy patient will tell eleven!

It isn't easy to serve patients and family members when they are distressed - particularly when they have a good reason for being upset; and calming the upset or angry patient is sometimes difficult, but extremely important. If an angry patient continues to express his or her anger and frustration without intervention, it can upset the entire practice. A special attribute of medical people is the ability to handle patient problems and complaints in a cool, calm and helpful manner.

But, what do you do when you encounter the angry patient?

The Solution: RESPOND TO COMPLAINTS QUICKLY AND CALMLY

Complaints can be valuable for the following reasons: (1) It's information you wouldn't have otherwise; (2) It's better to have negative information than *no* information; and (3) It gives you the opportunity to correct the situation.

The Technical Assistance Research Program (one survey arm of the United States Government) has issued a report which puts complaint-handling protocols in sharp perspective. Their research shows the chances of keeping a customer (patient) vary with the quality of the response as follows:

Chances of keeping a patient	When you:
70%	Listen to the complaint and promise a solution.
90%	Listen, promise, and respond.
130%	Listen, promise, and respond quickly.

The study shows when a staff member listens, promises to correct the problem, and follows through on a timely basis - *patients are more loyal than if the problem had never occurred!* In fact, these satisfied patients are likely to refer others to the practice as a result of the responsive problem-solving service.

The implication for all practices is that an effective complaint-handling procedure is a requisite for maintaining patient loyalty and stimulating referrals.

The following protocol is recommended:

- Staff members must practice proven techniques for dealing with patients when complaints arise (including protocols for referring complaints to the administrator and physicians).
- Every member of the staff is to report patient complaints (use Review of Concern" form as shown on page 646).
- One member of the practice (usually the office manager/administrator) is designated to receive the complaint notification, coordinate immediate response, and prepare a monthly report.
- Physicians and management hold regular staff meetings to review complaints and discuss issues for improvement.

Continued on page 647

REVIEW OF CONCERN

Date ____________________

Name of patient or person with concern ____________________

Name of staff member(s) involved ____________________

____

____

Summary of incident

____

____

____

____

How was the problem resolved?

____

____

____

____

How can a similar incident be prevented in the future?

____

____

____

____

Was the physician notified?	YES ☐	NO ☐
Was the patient/person contacted regarding resolution?	YES ☐	NO ☐
Did the patient/person express pleasure with the final outcome?	YES ☐	NO ☐

Comments:

____

____

____

Discover The Elegance Of A Hybrid

At first glance, it's the *beauty* of a rose that catches the eye. The vibrant color. The delicately shaped petals. But study it more closely, and its *elegance* becomes apparent—a gentle blend of softness and strength.

At first glance, it's the *enhanced performance* of Vaseretic that catches the eye. But study Vaseretic more closely, and its *elegance* becomes apparent. The way its one-tablet, once-a-day dosage minimizes multiple medications. Minimizes insurance copayments. And minimizes potassium supplementation.

A hybrid ***blending of tolerability and power*** that's available for the right patient. Vaseretic is indicated for the treatment of hypertension in patients for whom combination therapy is appropriate.

And an elegant discovery for your practice.

USE IN PREGNANCY: When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, Vaseretic® (Enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, *Fetal/Neonatal Morbidity and Mortality.*

VASERETIC® 10-25
Enalapril Maleate-Hydrochlorothiazide

Next

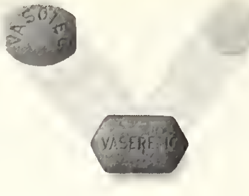
Dosage must be individualized; the fixed combination is not for initial therapy.

Evaluation of the hypertensive patient should always include assessment of renal function.

For a Brief Summary of Prescribing Information, see adjacent pages.

TABLETS
VASERETIC®
(ENALAPRIL MALEATE-HYDROCHLOROTHIAZIDE)

USE IN PREGNANCY: When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC (Enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, *Fetal/Neonatal Morbidity and Mortality.*



CONTRAINDICATIONS: VASERETIC is contraindicated in patients who are hypersensitive to any component of this product and in patients with a history of angioedema related to previous treatment with an angiotensin converting enzyme inhibitor. Because of the hydrochlorothiazide component, this product is contraindicated in patients with anuria or hypersensitivity to other sulfonamide-derived drugs.

WARNINGS: *General, Enalapril Maleate; Hypotension:* Excessive hypotension was rarely seen in uncomplicated hypertensive patients but is a possible consequence of enalapril use in severely salt/volume depleted persons such as those treated vigorously with diuretics or patients on dialysis.

Syncope has been reported in 1.3 percent of patients receiving VASERETIC. In patients receiving enalapril alone, the incidence of syncope is 0.5 percent. The overall incidence of syncope may be reduced by proper titration of the individual components. (See PRECAUTIONS, *Drug Interactions*, and ADVERSE REACTIONS.)

In patients with severe congestive heart failure, with or without associated renal insufficiency, excessive hypotension has been observed and may be associated with oliguria and/or progressive azotemia, and rarely with acute renal failure and/or death. Because of the potential fall in blood pressure in these patients, therapy should be started under very close medical supervision. Such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart or cerebrovascular disease, in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses, which usually can be given without difficulty once the blood pressure has increased after volume expansion.

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis and/or larynx has been reported in patients treated with angiotensin converting enzyme inhibitors, including enalapril. In such cases VASERETIC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis or larynx, likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided.** (See ADVERSE REACTIONS.)

Patients with a history of angioedema unrelated to ACE inhibitor therapy may be at increased risk of angioedema while receiving an ACE inhibitor (see also CONTRAINDICATIONS).

Neutropenia/Agranulocytosis: Another angiotensin converting enzyme inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Lithium generally should not be given with thiazides (see PRECAUTIONS, *Drug Interactions, Enalapril Maleate and Hydrochlorothiazide*).

Pregnancy; Enalapril-Hydrochlorothiazide: There was no teratogenicity in rats given up to 90 mg/kg/day of enalapril (150 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose) or in mice given up to 30 mg/kg/day of enalapril (50 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose). At these doses, fetotoxicity expressed as a decrease in average fetal weight occurred in both species. No fetotoxicity occurred at lower doses, 30/10 mg/kg/day of enalapril-hydrochlorothiazide in rats and 10/10 mg/kg/day of enalapril-hydrochlorothiazide in mice.

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC should be discontinued as soon as possible. (See *Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality*, below.)

Enalapril Maleate; Fetal/Neonatal Morbidity and Mortality: ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of VASERETIC as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment.

If oligohydramnios is observed, VASERETIC should be discontinued unless it is considered lifesaving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means of reversing hypotension and/or substituting for disordered renal function. Enalapril, which crosses the placenta, has been removed from neonatal circulation by peritoneal dialysis with some clinical benefit, and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure.

No teratogenic effects of enalapril were seen in studies of pregnant rats, and rabbits. On a mg/kg basis, the doses used were up to 333 times (in rats), and 50 times (in rabbits) the maximum recommended human dose.

Hydrochlorothiazide; Teratogenic Effects: Reproduction studies in the rabbit, the mouse and the rat at doses up to 100 mg/kg/day (50 times the human dose) showed no evidence of external abnormalities of the fetus due to hydrochlorothiazide. Hydrochlorothiazide given in a two-litter study in rats at doses of 4 - 5.6 mg/kg/day (approximately 1 - 2 times the usual daily human dose) did not impair fertility or produce birth abnormalities in the offspring. Thiazides cross the placental barrier and appear in cord blood.

Nonteratogenic Effects: These may include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

PRECAUTIONS: *General; Enalapril Maleate; Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe congestive heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with angiotensin converting enzyme inhibitors, including enalapril, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20 percent of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent pre-existing renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when enalapril has been given concomitantly with a diuretic. This is more likely to occur in patients with pre-existing renal impairment. Dosage reduction of enalapril and/or discontinuation of the diuretic may be required.

Evaluation of the hypertensive patient should always include assessment of renal function.

Hemodialysis Patients: Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes (e.g., AN 69*) and treated concomitantly with an ACE inhibitor. In these patients consideration should be given to using a different type of dialysis membrane or a different class of antihypertensive agent.

Hyperkalemia: Elevated serum potassium (greater than 5.7 mEq/L) was observed in approximately one percent of hypertensive patients in clinical trials treated with enalapril alone. In most cases these were isolated values which resolved despite continued therapy, although hyperkalemia was a cause of discontinuation of therapy in 0.28 percent of hypertensive patients. Hyperkalemia was less frequent (approximately 0.1 percent) in patients treated with enalapril plus hydrochlorothiazide. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with enalapril. (See *Drug Interactions.*)

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Warning signs or symptoms of fluid and electrolyte imbalance, irrespective of cause, include dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, confusion, seizures, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or after prolonged therapy. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia may cause cardiac arrhythmia and may also sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Because enalapril reduces the production of aldosterone, concomitant therapy with enalapril attenuates the diuretic-induced potassium loss (see *Drug Interactions, Agents Increasing Serum Potassium*).

Although any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease), chloride replacement may be required in the treatment of metabolic alkalosis.

Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

In diabetic patients dosage adjustments of insulin or oral hypoglycemic agents may be required. Hyperglycemia may occur with thiazide diuretics. Thus latent diabetes mellitus may become manifest during thiazide therapy.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

If progressive renal impairment becomes evident consider withholding or discontinuing diuretic therapy.

Thiazides have been shown to increase the urinary excretion of magnesium; this may result in hypomagnesemia.

Thiazides may decrease urinary calcium excretion. Thiazides may cause intermittent and slight elevation of serum calcium in the absence of known disorders of calcium metabolism. Marked hypercalcemia may be evidence of hidden hyperparathyroidism. Thiazides should be discontinued before carrying out tests for parathyroid function.

Increases in cholesterol and triglyceride levels may be associated with thiazide diuretic therapy.

Information for Patients; Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

Pregnancy: Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

NOTE. As with many other drugs, certain advice to patients being treated with VASERETIC is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions; Enalapril Maleate; Hypotension—Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS.)

Agents Causing Renin Release: The antihypertensive effect of enalapril is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents. Enalapril has been used concomitantly with beta adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine and prazosin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: Enalapril attenuates diuretic-induced potassium loss. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia they should be used with caution and with frequent monitoring of serum potassium.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant enalapril and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Hydrochlorothiazide; When administered concurrently the following drugs may interact with thiazide diuretics:

Alcohol, barbiturates, or narcotics—potentiation of orthostatic hypotension may occur.

Antidiabetic drugs (oral agents and insulin)—dosage adjustment of the antidiabetic drug may be required.

Other antihypertensive drugs—additive effect or potentiation.

Cholestyramine and colestipol resins—Absorption of hydrochlorothiazide is impaired in the presence of anionic exchange resins. Single doses of either cholestyramine or colestipol resins bind the hydrochlorothiazide and reduce its absorption from the gastrointestinal tract by up to 85 and 43 percent, respectively.

Corticosteroids, ACTH—intensified electrolyte depletion, particularly hypokalemia.

Pressor amines (e.g., norepinephrine)—possible decreased response to pressor amines but not sufficient to preclude their use.

Skeletal muscle relaxants, nondepolarizing (e.g., tubocurarine)—possible increased responsiveness to the muscle relaxant.

Lithium—should not generally be given with diuretics. Diuretic agents reduce the renal clearance of lithium and add a high risk of lithium toxicity. Refer to the package insert for lithium preparations before use of such preparations with VASERETIC.

Non-steroidal Anti-inflammatory Drugs—In some patients, the administration of a non-steroidal anti-inflammatory agent can reduce the diuretic, natriuretic, and antihypertensive effects of loop, potassium-sparing and thiazide diuretics. Therefore, when VASERETIC and non-steroidal anti-inflammatory agents are used concomitantly, the patient should be observed closely to determine if the desired effect of the diuretic is obtained.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Enalapril in combination with hydrochlorothiazide was not mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril-hydrochlorothiazide did not produce DNA single strand breaks in an *in vitro* alkaline elution assay in rat hepatocytes or chromosomal aberrations in an *in vivo* mouse

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bone marrow assay.

Enalapril Maleate: There was no evidence of a tumorigenic effect when enalapril was administered for 106 weeks to rats at doses up to 90 mg/kg/day (150 times* the maximum daily human dose). Enalapril has also been administered for 94 weeks to male and female mice at doses up to 90 and 180 mg/kg/day, respectively, (150 and 300 times* the maximum daily dose for humans) and showed no evidence of carcinogenicity.

Neither enalapril maleate nor the active diacid was mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril was also negative in the following genotoxicity studies. rec-assay, reverse mutation assay with *E. coli,* sister chromatid exchange with cultured mammalian cells, and the micronucleus test with mice, as well as in an *in vivo* cytogenic study using mouse bone marrow.

There were no adverse effects on reproductive performance in male and female rats treated with 10 to 90 mg/kg/day of enalapril.

Hydrochlorothiazide: Two-year feeding studies in mice and rats conducted under the auspices of the National Toxicology Program (NTP) uncovered no evidence of a carcinogenic potential of hydrochlorothiazide in female mice (at doses of up to approximately 600 mg/kg/day) or in male and female rats (at doses of up to approximately 100 mg/kg/day). The NTP, however, found equivocal evidence for hepatocarcinogenicity in male mice

Hydrochlorothiazide was not genotoxic *in vitro* in the Ames mutagenicity assay of *Salmonella typhimurium* strains TA 98, TA 100, TA 1535, TA 1537, and TA 1538 and in the Chinese Hamster Ovary (CHO) test for chromosomal aberrations, or *in vivo* in assays using mouse germinal cell chromosomes, Chinese hamster bone marrow chromosomes, and the *Drosophila* sex-linked recessive lethal trait gene. Positive test results were obtained only in the *in vitro* CHO Sister Chromatid Exchange (clastogenicity) and in the Mouse Lymphoma Cell (mutagenicity) assays, using concentrations of hydrochlorothiazide from 43 to 1300 μg/mL, and in the *Aspergillus nidulans* non-disjunction assay at an unspecified concentration.

Hydrochlorothiazide had no adverse effects on the fertility of mice and rats of either sex in studies wherein these species were exposed, via their diet, to doses of up to 100 and 4 mg/kg, respectively, prior to conception and throughout gestation.

Pregnancy; Pregnancy Categories C (first trimester) *and D* (second and third trimesters). See WARNINGS, *Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.*

Nursing Mothers: Enalapril and enalaprilat are detected in human milk in trace amounts Thiazides do appear in human milk. Because of the potential for serious reactions in nursing infants from either drug, a decision should be made whether to discontinue nursing or to discontinue VASERETIC, taking into account the importance of the drug to the mother

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: VASERETIC has been evaluated for safety in more than 1500 patients, including over 300 patients treated for one year or more. In clinical trials with VASERETIC no adverse experiences peculiar to this combination drug have been observed Adverse experiences that have occurred, have been limited to those that have been previously reported with enalapril or hydrochlorothiazide

The most frequent clinical adverse experiences in controlled trials were: dizziness (8.6 percent), headache (5.5 percent), fatigue (3.9 percent) and cough (3.5 percent). Adverse experiences occurring in greater than two percent of patients treated with VASERETIC in controlled clinical trials were muscle cramps (2.7 percent), nausea (2.5 percent), asthenia (2.4 percent), orthostatic effects (2 3 percent), impotence (2.2 percent), and diarrhea (2.1 percent).

Clinical adverse experiences occurring in 0.5 to 2.0 percent of patients in controlled trials included: *Body As A Whole:* Syncope, chest pain, abdominal pain; *Cardiovascular:* Orthostatic hypotension, palpitation, tachycardia; *Digestive:* Vomiting, dyspepsia, constipation, flatulence, dry mouth; *Nervous/Psychiatric.* Insomnia, nervousness, paresthesia, somnolence, vertigo; *Skin:* Pruritus, rash; *Other* Dyspnea, gout, back pain, arthralgia, diaphoresis, decreased libido, tinnitus, urinary tract infection.

Angioedema: Angioedema has been reported in patients receiving VASERETIC (0.6 percent). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis and/or larynx occurs, treatment with VASERETIC should be discontinued and appropriate therapy instituted immediately (See WARNINGS.)

Hypotension: In clinical trials, adverse effects relating to hypotension occurred as follows: hypotension (0.9 percent), orthostatic hypotension (1.5 percent), other orthostatic effects (2.3 percent). In addition syncope occurred in 1.3 percent of patients. (See WARNINGS.)

Cough: See PRECAUTIONS, *Cough.*

Clinical Laboratory Test Findings; Serum Electrolytes: See PRECAUTIONS

Creatinine, Blood Urea Nitrogen: In controlled clinical trials minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.6 percent of patients with essential hypertension treated with VASERETIC. More marked increases have been reported in other enalapril experience. Increases are more likely to occur in patients with renal artery stenosis. (See PRECAUTIONS.)

Serum Uric Acid, Glucose, Magnesium, and Calcium: See PRECAUTIONS.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g percent and 1.0 vol percent, respectively) occur frequently in hypertensive patients treated with VASERETIC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1 percent of patients discontinued therapy due to anemia.

Liver Function Tests: Rarely, elevations of liver enzymes and/or serum bilirubin have occurred

Other adverse reactions that have been reported with the individual components are listed below and, within each category, are in order of decreasing severity.

Enalapril Maleate—Enalapril has been evaluated for safety in more than 10,000 patients. In clinical trials adverse reactions which occurred with enalapril were also seen with VASERETIC. However, since enalapril has been marketed, the following adverse reactions have been reported: *Body As A Whole* Anaphylactoid reactions (see PRECAUTIONS, *Hemodialysis Patients*); *Cardiovascular:* Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high risk patients (see WARNINGS, *Hypotension*); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances including atrial tachycardia and bradycardia; atrial fibrillation; hypotension; angina pectoris; *Digestive:* Ileus, pancreatitis, hepatic failure, hepatitis (hepatocellular [proven on rechallenge] or cholestatic jaundice), melena, anorexia, glossitis, stomatitis, dry mouth; *Hematologic.* Rare cases of neutropenia, thrombocytopenia and bone marrow depression. Hemolytic anemia, including cases of hemolysis in patients with G-6-PD deficiency, has been reported; a causal relationship to enalapril has not been established. *Nervous System/Psychiatric:* Depression, confusion, ataxia, peripheral neuropathy (e.g., paresthesia, dysesthesia); *Urogenital:* Renal failure, oliguria, renal dysfunction (see PRECAUTIONS), flank pain, gynecomastia; *Respiratory:* Pulmonary infiltrates, bronchospasm, pneumonia, bronchitis, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection; *Skin:* Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pemphigus, alopecia, flushing, photosensitivity; *Special Senses:* Blurred vision, taste alteration, anosmia, conjunctivitis, dry eyes, tearing.

Miscellaneous: A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia/myositis, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash and other dermatologic manifestations.

Fetal/Neonatal Morbidity and Mortality: See WARNINGS, *Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.*

Hydrochlorothiazide—Body as a Whole: Weakness; *Digestive* Pancreatitis, jaundice (intrahepatic cholestatic jaundice), sialadenitis, cramping, gastric irritation, anorexia, *Hematologic:* Aplastic anemia, agranulocytosis, leukopenia, hemolytic anemia, thrombocytopenia; *Hypersensitivity:* Purpura, photosensitivity, urticaria, necrotizing angiitis (vasculitis and cutaneous vasculitis), fever, respiratory distress including pneumonitis and pulmonary edema, anaphylactic reactions, *Musculoskeletal:* Muscle spasm; *Nervous System/Psychiatric:* Restlessness; *Renal:* Renal failure, renal dysfunction, interstitial nephritis (see WARNINGS); *Skin:* Erythema multiforme including Stevens-Johnson syndrome, exfoliative dermatitis including toxic epidermal necrolysis, alopecia, *Special Senses:* Transient blurred vision, xanthopsia

* Based on patient weight of 50 kg.

For more detailed information, consult your DuPont Pharma Representative or see Prescribing Information.

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Practice Management - Continued from page 645

- Management responds to every complaint in writing within one week (whether the problem is resolved or not), with an explanation and apology (if appropriate).

Rules for handling complaints should include:

- Stay calm; don't take complaints personally.
- Listen for the facts; let the patient tell the whole story, and make sure you understand the source of the problem.
- Don't respond to complaints with arguments or excuses; apologize if errors have been made.
- Refer abusive patients immediately to the administrator or physician.
- Let the complainer know you're interested in solving the problem
- Be empathetic.
- Describe what you plan to do to solve the problem; never make promises you can't keep; offer alternatives.
- Follow through on whatever promises you make and ensure the problem is solved.
- Monitor feedback; and let your supervisor/administrator know how you handled the problem.
- Thank the patient for letting you help with the problem.

Now to implement this policy . . .

(1) Convene a staff meeting.
(2) Discuss the need for handling patient complaints quickly and effectively.
(3) Review your practice protocols for handling patient complaints.
(4) Give each staff member a copy of the "Review of Complaint" form on page 646 (or similar form being used in your practice).
(5) Ensure your patients are satisfied with the follow-through when they have problems.

If you have questions for Danielle Halsel, write to Practice Management, c/o ***Missouri Medicine****, P.O. Box 1028, Jefferson City, MO 65102 or call her at (913)541-0050.*

My Friend, James William Bagby
1908-1990

Wilfred E. Wooldridge, MD

If we are fortunate we enjoy a few friendships, very few, which ripen through the years and become so prized that death may terminate the association, but never ends it. That was my feeling for James W. Bagby; fellow dermatologist, teacher and source of unparalleled wit.

Our acquaintance dated from the time I began residency in St. Louis in 1946, at the old Barnard Free Skin and Cancer Hospital. I was just out of the army. James left the navy not much earlier, had resumed practice in Saint Louis and was on the teaching staff of the Washington University Hospitals.

I have no claim to our early association. I was only one of many residents he knew. But we shared a common bond; native Missourians who knew and loved our clear, gravelly streams and who got on them as often as possible.

To me, even more important than our love of fishing, was James's wry sense of humor. I hadn't met him many times before he confided one day, "Willy, the reason I became a dermatologist was because I never could hear anything through a stethoscope." Then came the crusher. "And what's more," he added, "neither can anyone else."

It wasn't long after that until he asked me to float the upper Meramec River with him. That was an unexpected, and most welcome, invitation. It was also the first of many floats, followed over the years by his coming to our lakes and rivers when I began practice in Springfield.

In those days it was an effort to get to the upper Meramec from St. Louis. Highway 66 was a tortuous, two-lane, crowded and dangerous road. We would leave home before daylight and return after dark, fighting traffic all the way. On one of those trips I learned James despised motorcycles. It happened this way. Somewhere around Sullivan we were overtaken by a cavalcade of motorcycles. One or two would pass at a time, then slow in front of us, making driving very tedious. When the last of the thirty or forty were safely beyond he confided, "If we are ever in another war I'll be too old to go. At that time I'm going to apply for a job on the draft board."

"Why would you do a thing like that," I asked.

"For the good of everyone. I'm going to sit there day after day. Every time a prospective inductee appears my first question will be "did you ever own or operate a motorcycle?" If the answer is "Yes", my reply will be "Go home, stay in the house and don't come outside until the war's over! You're too crazy to be any help to your country!"

I very well recall a time when James was perplexed by an efficient, but officious, secretary who had been with him overlong. That situation spawned one of his finest sayings. "A doctor should tear through his office each five years and fire everybody in sight. Those who stay too long have quiet and malicious ways of becoming liabilities."

I got in on hundreds of equally salty comments over the years, but James was at his best with "Bagby's Laws." I never knew how many Bagby's Laws there were, but I learned some of them. Bagby's First Law had something to do with his family. He never told me what it was. Bagby's Fourth Law explained how to determine when the water was barely clear enough for proper fly fishing. Bagby's Sixth Law was, "One should never tamper with his female patients. Aside from the moral implications, it simply isn't sporting." Bagby's Seventh Law sternly stated, "Women are incapable of backing automobiles." In greater detail it continued, "Place an automobile under the goal post of a football field. Put a woman in it. Tell her to back it to the opposite goal post. Before she gets there she will be out of bounds on both sides."

Yes, I continue to miss James Bagby sorely. For me, there has not been, and will not be, anyone to take his place. But I'll bet heaven is having a grand time.

COMPUTERIZED MEDICAL RECORDS DREAM OR REALITY?

Robert R. Hausam, MD and E. Andrew Balas, MD, PhD

For over 25 years many clinicians and others working in health-related fields have envisioned the day when physicians will use a computer on their desk or at the bedside to enter and retrieve the medical records and other information needed to care for their patients. Pioneers in medical informatics have been working during this time to develop the concepts and systems to make this possible, but so far, with only a few exceptions, this has been still mostly a dream. However, we may now be on the threshold of the time when these systems will be implemented on a large scale and become an integral part of the practice of clinical medicine, making the vision no longer a dream but a reality.

PREVIOUS CONTRIBUTIONS

A number of pioneering computerized medical record systems have been developed, and some are currently in use. Primary examples of ambulatory care systems include COSTAR (from Massachusetts General Hospital and the Harvard Community Health Plan), the Regenstrief Medical Record System (from Indiana University Medical Center) and TMR (from Duke University).[1] These systems offer varying degrees of medical record and decision support capabilities, and both COSTAR and TMR are commercially available. The best example of a hospital-based system is the HELP system (from the University of Utah).[2] It has a primary emphasis of decision support, and is also commercially available with several installed sites. These systems have provided a laboratory for developing and testing many of the concepts and techniques required for further development of fully computerized medical records systems. However, all have suffered from limitations which have prevented their widespread acceptance and use.

TERMINOLOGY

There has been no consensus on the terminology used to describe the current generation of computerized medical record systems. However, this may be changing. The Institute of Medicine of the National Academy of Sciences recently released a report discussing the need and outlining a vision for the continuing development and implementation of this type of system, which they termed the *computer-based patient record (CPR).* [3] This terminology has subsequently had fairly widespread use. It may become the accepted standard, and will be used throughout the remainder of this paper.

POLITICAL AND ECONOMIC CONSIDERATIONS

Forces appear to be converging at this time which are moving the world of clinical medicine steadily closer to the use of CPR systems. A primary push in this direction is coming from the government, private insurers and the legal profession. Changes in regulations, reimbursement mechanisms and the legal climate in recent years have significantly increased the burden of documentation and information handling required to practice clinical medicine. Managing this information using paper-based systems is becoming increasingly more difficult and costly.

CPR systems, though not yet mandated, are increasingly being viewed as attractive due to their potential for improving the efficiency of information management. In addition, it appears that a new push for the use of these systems is likely to result from the current government efforts in health care reform. Physicians in the near future will likely be required to submit health care claims electronically in order to be reimbursed. It is also quite likely that, at the very least, clinical information for claims and quality control audits will be required in electronic form. Beyond that, the possibility does exist that the government will at some point mandate the use of fully computerized medical records.

ADDITIONAL BENEFITS OF CPR SYSTEMS

Besides improving the management of medical record information, the use of CPR systems can provide significant additional benefits. The CPR system is the focal point for entering and retrieving all informa-

Continued on page 650

Continued from page 649

tion needed for patient care, and its use becomes an integral part of the physician's work routine. This provides the opportunity to easily and efficiently integrate other related functions. Reminder, patient recall and decision support functions can be incorporated, and have been pioneered especially in the HELP, Regenstrief and COSTAR systems. Examples of possible decision support functions include monitoring for drug to drug incompatibilities, monitoring for compliance with standard treatment protocols, automated access to medical literature, and expert systems to aid in diagnosis.

TECHNOLOGY

In the past, lack of adequate technology has been a barrier to the implementation and use of CPR systems in the real world of medical practice, both in the office and in the hospital. These technological limitations have prevented the currently available systems from achieving widespread acceptance and use. Fortunately, however, as the need for CPR systems has become more acute and possible mandates are looming ever closer, technology has advanced to the point that practical and much more usable implementations at a reasonable cost appear to be just now becoming available. Few of the newer implementations have been adequately tested and proven, but at least some do appear to hold significant promise.

There has been nothing short of a revolution in both hardware and software technology in the past few years. Performance in both areas has significantly improved while costs for most items have decreased, in some cases dramatically. Price/performance and cost/benefit ratios have both improved markedly even in the past one to two years. Probably the most significant advances have been in increased processing speed, new data storage devices and techniques, and the development and widespread adoption of graphical user interfaces. We now have the opportunity to put adequate information processing power right on physicians' desks or in their laps, and we can provide them with the tools to input and access this information quickly and efficiently.

PHYSICIAN-COMPUTER-INTERFACE

Previously, the interface between the physician and the computer has been one of the biggest stumbling blocks thwarting widespread adoption of CPR systems. Most interfaces until now have suffered from being too slow, too difficult to learn and use, too restrictive or some combination of the above. The new technology, however, provides an opportunity to make significant improvements. Graphical interfaces allow information to

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be presented in familiar formats (i.e. desktops, notebooks, charts, etc.), allowing a natural style of interaction without requiring the use of special commands and "computer language." The possibility of practical use of voice recognition is also very enticing. This has been part of the dream of many physicians, and has been considered essential by some before adoption of CPR systems can even be considered. Voice recognition is still a difficult problem, but intensive research is being done in this area, and significant progress is being made. It is not yet possible to replace the physician's dictating machine, but it is now possible to use voice recognition to enter some of the information needed by a CPR system.

FUTURE DIRECTIONS AND GOALS

In spite of the progress, defining which interface tools to use and how to optimally integrate them and present them to the users is still very much a research question at this time. Commercial systems are rapidly adopting many of the new technologies, but much work still needs to be done to take advantage of the capabilities available today, let alone those that are likely to be available in the near future. However, using a combination of the best features of the currently available interface tools, it should be possible to build CPR systems with interfaces that even busy physicians will find satisfactory and will be willing to use.

CPR systems are not yet fully a reality, but are now much more than just a dream. Hopefully, their use will ultimately prove to be of benefit not just to physicians, but also to their patients and to society as a whole. We should anticipate the opportunity for most of us to be able to evaluate them firsthand in the fairly near future.

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NEXT MONTH:

This is the first of two articles on the topic of computerized medical records and CPR systems. The discussion next month will cover in more detail the current state-of-the-art and probable future directions in the implementation of CPR systems.

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CONSUMPTION OF FRUITS AND VEGETABLES IN MISSOURI

Jeffrey P. Mayer, PhD, Carol A. Smith, MSPH, Cheryl Houston, MS, RD,
Ethel Smith, MS, RD and Joan C. Wilkerson, BA

High consumption of fruits and vegetables has been linked with a reduced risk of several important chronic diseases. The authors utilized telephone survey techniques to assess the level of fruit and vegetable consumption among adult Missouri residents. Only 28% of respondents reported consumption of five servings of fruits and vegetables per day. Older females had the highest rate of consuming five servings per day, while young males had the lowest rate. These findings, in conjunction with national data, show the need for increasing emphasis on the "5 A Day" campaign.

Poor dietary practices, particularly excess fat and inadequate fiber intake, have been associated with increased risk for a number of chronic diseases.[1] For example, it is estimated that as much as 35% of cancer mortality in the United States may be related to dietary factors.[2-4] Based on these findings the American Cancer Society,[5] the US Department of Agriculture,[6] the Surgeon General,[7] and the Institute of Medicine[8] are supporting the following changes in the average American diet: a reduction in total calories from dietary fat; an increase in the variety of foods included in the diet; and an increase in consumption of foods high in complex carbohydrates. Fruits and vegetables are excellent sources of complex carbohydrates and can serve as substitutes for foods high in fat.

Accordingly, several recent initiatives have promoted consumption of at least 5 servings of fruits and vegetables every day. Goals for the year 2000 for both the nation[9] and Missouri[10] specify increasing adult consumption of fruits and vegetables to at least five daily servings. The National Research Council in its landmark 1989 report, *Diet and Health: Implications for Reducing Chronic Disease Risk*,[1] recommended that American adults "every day eat 5 or more servings of a combination of vegetables and fruits." In partnership with the produce industry (**i.e.**, the Produce for Better Health Foundation), the National Cancer Institute has launched the "5 A Day for Better Health" campaign. The message of 5 A Day is that eating more fruits and vegetables can improve health and reduce the risk of chronic diseases. This campaign involves a national media program and a point-of-purchase educational program in cooperation with supermarkets across the nation. The campaign includes prominent retail food chains in St. Louis, Kansas City, and other Missouri cities.

In this article we report data from a nutrition survey of a representative sample of Missouri adults to characterize patterns of fruit and vegetable consumption.

METHODS

We employed a three-stage sampling technique based on the Waksberg method[11] to select Missourians 18 years of age and older for telephone interview. The interviews were conducted in August-November 1992 and January-February 1993. The period between Thanksgiving and mid-January was excluded due to possible atypical eating patterns during the holiday season. After deleting 36 respondents who did not answer the fruit and vegetable items, the total sample size was 839.

We analyzed responses to the question: "How many total servings of fruits and vegetables do you eat daily?" Most analyses involved cross classifying dichotomized responses to this question (that is, 4 or less *versus* 5 or greater) with demographics. For simplicity, the category of five or more servings per day is referred to as "five per day" in the remainder of this article. As appropriate for standard random digit dial methods, the data were weighted by selection probabilities, and to the 1990 Missouri Current Population Survey by gender, age, and race. Percentages and their standard errors were computed using SUDAAN, a statistical package for complex sampling designs.

RESULTS

Figure 1 presents daily servings of fruits and vegetables consumed by Missourians. Almost half of respondents consumed only 1-2 servings per day with about a quarter each consuming 3-4 or 5 or more servings. Only 27.0% reported eating five per day.

Figure 2 illustrates variation in consumption of five or more daily servings by age and sex. For both males and females the percentage eating five per day increased with age. Older females had the highest rate of consuming five per day, while young males had the lowest rate. Regardless of age, females were more likely to consume five per day (32.1%) than males (23.2%). The eldest age group had a higher rate of eating five per day (38.2%) than both younger age groups (21.1% and 25.7% for the 18-34 and 35-54 age groups respectively). Our study also showed that Whites were slightly more likely to consume five per day (28.4%) than Blacks (25.6%). Slightly higher consumption rates also were observed among Missourians with more than 12 years of education (30.8% *versus* 25.5%), and among those from households with incomes greater than $20,000 (29.0% *versus* 24.4%).

DISCUSSION

Our results suggest there is ample room for progress in improving dietary practices. Only 28% of Missouri adults currently consume 5 or more servings of fruits or vegetables per day, well short of the *Healthy Missourians 2000* objective that calls for achieving 50%.[10]

Our results are similar to other national and state level findings. Early data (1976-80) on US fruit and vegetable consumption from the National Health and Nutrition Examination Survey indicated that 19% of Americans consumed five per day.[12] In accord with US Department of Agriculture production and import data, more recent surveys have shown a slight increase in fruit and vegetable consumption. The 1991 National Cancer Institute 5 A Day baseline study, a nationally representative telephone survey, reported 23% of American adults at five per day.[13] A 1989 California survey indicated 34% of respondents were eating five per day. However, as acknowledged by the authors, the late summer, early fall timing of interviews in this study probably led to an inflated (seasonal) estimate.[14] Findings for demographic subgroups also are generally consistent between this study and others.

Reasons for consuming fewer than the recommended number of fruits and vegetables provides valuable information for an educational campaign. Of particular note is that 42% of those eating less than five per day reported that they thought they were eating enough fruits and vegetables. About 25% stated that fruits and vegetables were too expensive, or that they were simply "not in the habit" of eating fruits and vegetables. Only small proportions of Missourians reported not liking the taste of fruits and vegetables, or that they took too long to prepare and cook.

Concordance of health messages from multiple, high credibility sources is a basic principle of health communication. Physicians and other health professionals can help by reinforcing information disseminated through the 5 A Day campaign. A major strength of the 5 A Day campaign is that it promotes a simple, positive message for better health (More information on the Missouri 5 A Day campaign can be obtained by writing Ethel Smith, MS, RD, Bureau of High Risk Intervention, Missouri Department of Health, 201 Business Loop 70 West, Columbia, MO 65203).

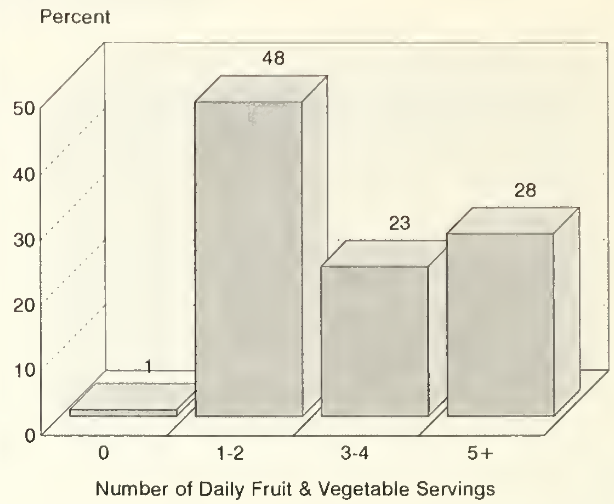

Figure 1. Distribution of daily servings of fruits and vegetables consumed by Missouri adults.

Several prominent and accessible patient education resources for nutrition exist. *Nutrition and Your Health: Dietary Guidelines for Americans* is published jointly by USDA and DHHS. In addition, USDA has recently released *The Food Guide Pyramid*. Both of these materials contain a strong 5 A Day message, and can be obtained from USDA's Human Nutrition Information Service (6505 Belcrest Road, Hyattsville, MD, 20782). The US Preventive Services Task Force report, *Guide to Clinical Preventive Services*, includes a chapter that reviews research on the effectiveness of brief physician counseling, and suggests specific nutrition counseling practices tailored to patient age[15] A recent national survey indicated that although primary care physicians hold very positive attitudes towards the use of nutrition in their practices, these favorable attitudes were not consistent with their reports of clinical performance.[16] Similarly, a Missouri survey of primary care physicians indicated that activity in nutrition education and counseling was relatively low, with reported barriers of lack of time and no financial reimbursement.[17]

The present findings are limited by the self-report nature of the telephone survey data. Dietary behaviors are notoriously difficult to measure with recall, social desirability and seasonal factors all contributing to unwanted variation.[18] Although diet items had the poorest test-retest reliabilities in one study of the data quality of telephone health behavior surveys,[19] more recent studies have shown reasonably high correlations be-

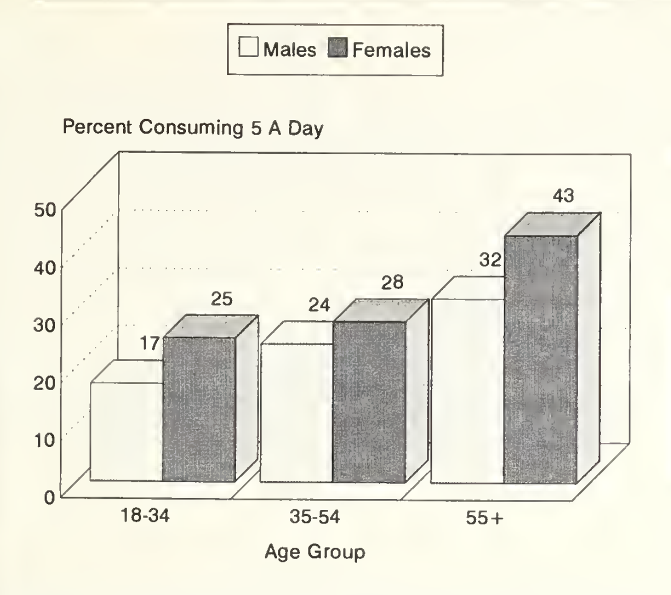

Figure 2. Distribution of consumption of five per day by Missouri adults by gender and age group.

tween telephone data and extensive food frequency interview methods.[20]

To achieve Missouri's Year 2000 objective for fruit and vegetable consumption, the current five per day consumption prevalence must nearly double. Clinicians can play a key role by reinforcing the 5 A Day theme in partnership with government agencies, voluntary health associations, TV and radio stations, and food retailers.

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BILIARY CYSTADENOMA:
A Case Report and Review of the Literature

Ralph Fairchild, MD, Jeffrey Reese, MD, Harvey Solomon, MD,
Paul Garvin, MD and Robert Esterl, MD

Biliary cystadenoma is a rare benign neoplasm usually found in the parenchyma of the right lobe of the liver. The lesions are usually septated and represent less than 5 percent of non-parasitic cysts of biliary origin.[1] Malignant degeneration to biliary cystadenocarcinoma is well documented[2], and recurrence is the rule following incomplete excision.[3]

CASE REPORT

The patient is a 46-year-old white woman with a mass noted in her superior abdomen on routine gynecologic examination. This mass was associated with early satiety and mild back pain. There was no history of pancreatitis, hepatitis, toxin exposure or travel. Family history was negative. Physical examination revealed a large mass palpable in the right upper quadrant which was firm but without tenderness. Laboratory included an essentially normal hepatic panel. The alkaline phosphatase was mildly elevated at 142. CT scan revealed a large multiloculated cyst in the left lobe of the liver (Fig. 1). The patient underwent a left hepatectomy with complete excision of the cyst (Fig. 2). The histologic examination revealed a large cyst lined by columnar epithelium consistent with a biliary cystadenoma. The patients postoperative course was smooth and she was discharged from the hospital on postoperative day number eight. Her alkaline phosphatase level dropped to 42 and the remainder of her liver panel remained normal.

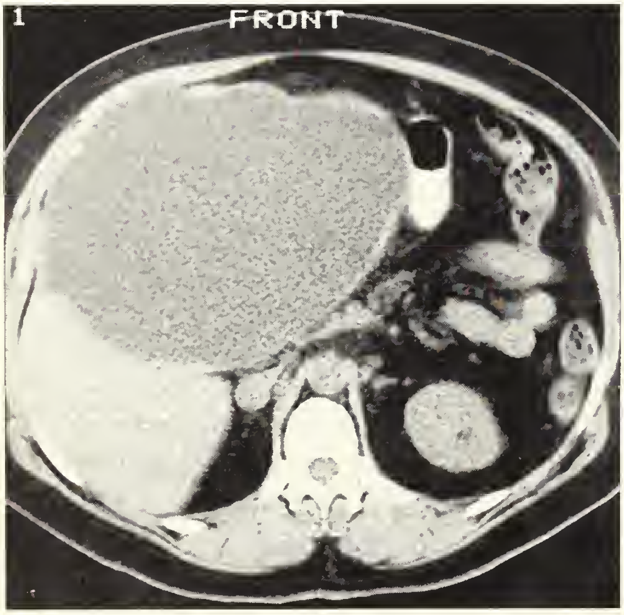

Figure 1

Six months postoperatively the patient is totally asymptomatic, her satiety and abdominal pain have resolved and her liver function continues to be normal.

DISCUSSION

Biliary cystadenoma is a rare neoplasm representing less than five percent of nonparasitic hepatic cysts of biliary origin. Various etiologies for biliary cystadenoma have been postulated however, its origin is still unproven. Current dogma suggests a congenital anomaly of the hepatobiliary anlage.[4] There is little evidence to support an acquired origin, and their is no association with oral contraceptives.[5] The presence of benign biliary-type epithelium in cystadenocarcinomas supports a theory of malignant transformation from benign cystadenomas.[6]

CLINICAL FINDINGS

Fully 85% of cystadenomas occur within the hepatic parenchyma however, they can be found in other locations such as the extra hepatic bile duct and gallbladder.[2] Middle-aged women are most commonly affected with chronic abdominal pain the most common symptom. Cholangitis and sepsis may occur[3] but are exceptional. Jaundice, nausea, vomiting, steatorrhea, early satiety and an abdominal mass may also occur.[5]

Confusion may exist in differentiating benign biliary cystadenoma from hydatid disease in endemic areas. Casoni's test and counter-immune electrophoresis are helpful in ruling out the diagnosis of hydatid disease, however, errors in diagnosis may still occur.[4]

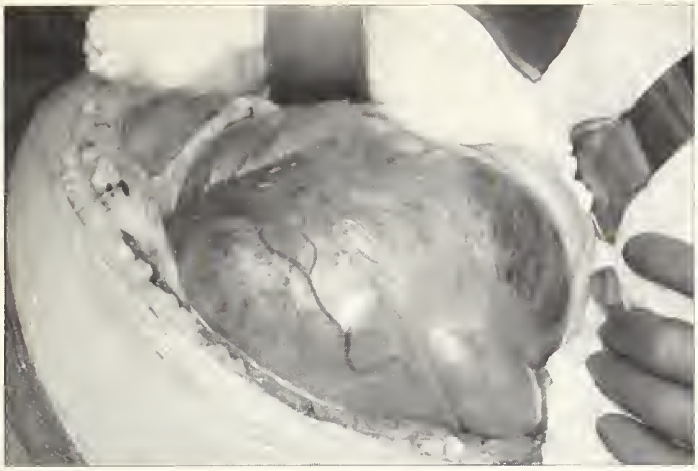

Figure 2

LABORATORY FINDINGS

Plain radiographic studies may show hepatic enlargement and displacement of surrounding tissues but are nonspecific. Hepatic scans may show filling defects but are also nonspecific.[5] Angiography[5] may reveal vessels surrounding an avascular intrahepatic structure. CT scanning and ultrasound are favored diagnostic procedures in some centers[3] cyst opacification and ERCP in other centers[1], and angiography in others.[2]

PATHOLOGIC FINDINGS

Grossly, cystadenomas usually consist of large multiloculated space occupying lesions containing fluid which can range from mucinous and brown to thin and clear. The cysts are usually lined by a single layer of columnar cells resting on a basement membrane (Fig. 3).[6] There may be occasional polypoid or papillary projections. Cytoplasmic vacuoles contain mucin. Supporting stroma is compacted and cellular resembling ovarian tissue. Adjacent hepatic parenchyma may show compression atrophy. Cystadenocarcinomas probably arise by malignant transformation from cystadenomas.[6]

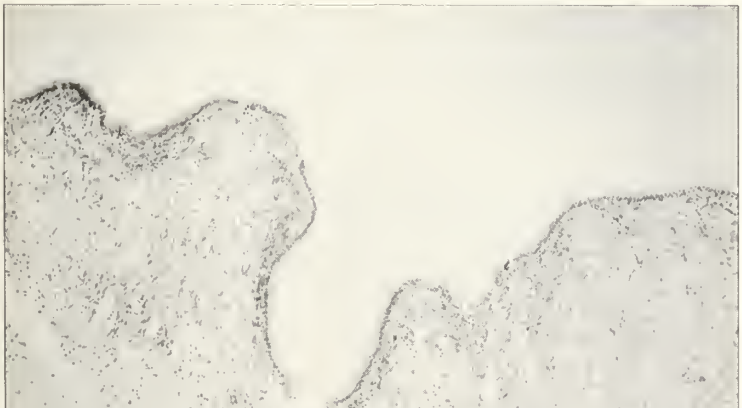

Figure 3

TREATMENT

Various therapeutic maneuvers including aspiration and partial excision (marsupialization) have been attempted. Incomplete excision results in a 90 to 100% recurrence rate[3], therefore total removal by either excision or resection is recommended.[1,3] Total extirpation totally prevents recurrence and the accompanying risk of malignant degeneration.

SUMMARY

Biliary cystadenoma is a rare benign neoplasma usually found in the right hepatic lobe of middle aged females. Symptoms are often minimal but chronic abdominal pain and early satiety may be present. If a mass is palpable, it is often large. Laboratory findings are nonspecific and preoperative confusion with hydatid disease is possible. Microscopically, the cysts are lined by a single layer of columnar cells resting on a basement membrane. The treatment is complete excision to exclude foci of cystadenocarcinoma and to prevent recurrence of a benign cystadenoma.

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Cholelithiasis: Seven Critical Questions

Steven M. Strasberg, MD

The management of cholelithiasis is usually straightforward, but there are a few special situations and questions which arise repeatedly. This paper deals with management of patients with asymptomatic stones, diabetic patients with stones, the relationships between stones and cancer, and patients without stones but who have typical pain. It also considers certain surgical topics of interest to primary care specialists, including that of safety of laparoscopic surgery, pain after surgery, and the role of incidental cholecystectomy.

Cholelithiasis is a very common condition, and its management is usually straightforward. However, there are a number of special situations that require particular considerations. While clinical studies have not provided us with conclusive answers in all of these areas, there are some valuable guidelines available.[1] The purpose of this paper is to discuss these problems and rationale for management.

Asymptomatic gallstones. At one time the need to advise patients with asymptomatic gallstones was very uncommon since asymptomatic stones were rarely diagnosed unless they were calcified. The diagnosis had to be made using a test that was specifically directed towards the gallbladder, such as oral cholecystography. Today, however, ultrasound is performed very widely for even minor gastrointestinal complaints. It is also done for nongastrointestinal problems such as renal or obstetrical complaints. Therefore, asymptomatic stones are discovered much more frequently and advice for asymptomatic gallstones is now often required.

Studies on the fate of asymptomatic stones are as old as this century. Many of the early studies suggested that asymptomatic stones were dangerous. A major reason for this conclusion was that patients with mild, but true biliary symptoms were included in the studies. The natural history of patients who are already symptomatic with biliary symptoms is quite different from that of patients who are truly asymptomatic. More recent studies have carefully excluded these patients with mild biliary symptoms. As a result, a different and much more benign picture has emerged.[2]

Table 1. Natural History of Gallstones

Incidence: Increasing in each decade.
25% of women, 12% of men have stones at age 60.
Stages: Asymptomatic: no symptoms
Symptomatic: biliary colic
Complicated: Acute Cholecystitis OR
Choledocholithiasis and its complications:
- Jaundice
- pancreatitis
- cholangitis

Conversion between Stages:
Asymptomatic to Symptomatic: 0.5-1% per year
Symptomatic to Complicated: 3-5% per year

The natural history of gallstone disease has three stages, asymptomatic, symptomatic, and complicated (Table 1). The meaning of asymptomatic stage is self explanatory. The symptomatic stage is characterized by biliary colic, and the complicated stage by acute cholecystitis or choledocholithiasis and its complications such as cholangitis and pancreatitis. Dyspepsia alone is not evidence of symptomatic gallstone disease. With rare exceptions patients do not pass from asymptomatic disease to complicated cholelithiasis. As a result the patient who has been asymptomatic but becomes symptomatic can be treated in a timely manner before there is much risk of developing complications. The rate of conversion from asymptomatic cholelithiasis to symptomatic cholelithiasis is somewhere between 0.5 and 1% per year. In all, about 20% of the patients who have no symptoms will develop symptoms sometime during their lives. Therefore, if one were to propose a policy of treating asymptomatic cholelithiasis, five patients would receive treatment for every patient that actually needed it. In keeping with the observation that gallstones almost always become symptomatic before they become complicated, one may review the entire literature in this area without finding a report of a patient who has died by managing asymptomatic cholelithiasis expectantly. Therefore, the bottom line for asymptomatic patients is that treatment is not usually indicated. This conclusion not only applies to surgical treatment, but to nonsurgical treatments as well.

What about patients with asymptomatic gallstones who have GI complaints, that do not seem to be biliary in origin. This problem is also more common than usually appreciated. It should be remembered that dyspepsia cannot be attributed to cholelithiasis, and that the only true symptom of uncomplicated gallbladder disease is pain. It is important for us to be able to separate patients who have problems such as irritable bowel syndrome from those that have biliary colic. Patients with irritable bowel syndrome do not benefit from cholecystectomy. In fact, they may be harmed. On the other hand patients with true biliary colic require cholecystectomy since once symptoms have developed the risk of developing complications is 3 to 5% per year. When the patient's pain is in the lower abdomen and is associated with abnormalities of bowel movements, particularly intermittent constipation, one can be fairly sure that the symptoms are not from the gallstones but from irritable bowel syndrome. Classical biliary colic has three components. The pain is upper abdominal in location, either in the epigastrium or upper quadrant. It is typically severe in nature and it comes on either after meals or wakes the patient at night. The nocturnal aspect is not often appreciated but is actually quite characteristic. The presence of any two of the three components of location, severity, and timing is enough to conclude that the gallstones are symptomatic. When one or none of these are present, the diagnosis is doubtful and one should not usually recommend cholecystectomy. It is obviously important to rule out other causes for the patient's symptoms in such cases.

As with other rules in medicine, there are exceptions to the advice that asymptomatic cholelithiasis should be treated expectantly (Table 2). The "porcelain" gallbladder is a rare condition in which the wall (not the stones) of the gallbladder becomes calcified. This is a particular form of chronic inflammation of the gallbladder and is associated with a high incidence of gallbladder cancer.[3] It is an absolute indication for cholecystectomy. Another indication for cholecystectomy is a mass in the gallbladder associated with the stones. This is usually an ultrasound diagnosis. Under these rare circumstances the presence of malignancy cannot be excluded and the gallbladder should be removed. These are two absolute indications for cholecystectomy in asymptomatic patients, but there are also relative indications. Gallstones in patients who have sickle cell anemia and are having crises that cannot be clearly differentiated from biliary colic, children, patients with choledocholithiasis, and patients with stones who have a family history of gallbladder cancer need to be considered carefully for cholecystectomy and the risks and benefits of the procedure under these circumstances, explained. Cholelithiasis in children and cholelithiasis in patients who have a family history of cancer are often indications for cholecystectomy because of the "worry" factor. This is understandable and treatment cannot be withheld when this occurs.

Table 2. Asymptomatic Gallstones - Summary of Management

Absolute indication for treatment
- Porcelain Gallbladder
- Mass in gallbladder or other suggestion of malignancy

Relative indication for treatment
- Sickle cell anemia with abdominal crises
- Choledocholithiasis
- Children with stones
- Family history of gallbladder cancer

No indication for treatment
- no symptoms or dyspepsia alone
- symptoms not compatible with biliary colic e.g., lower bowel symptoms suggestive of IBS

Cholelithiasis in diabetics. It has been stated that many problems in medicine come from doing too much too soon or too little too late. Nowhere is this more true than in treatment of cholelithiasis in diabetics. Thus, diabetics with asymptomatic gallstones are advised to have cholecystectomy because of the risk of complications from stones, while those who have symptoms are advised against cholecystectomy because of the increased risk of complications from surgery. Both are incorrect. In several studies it has been shown that diabetics have no greater chance of developing symptoms from gallstones than members of the general population.[4] Also, they are at no greater risk of developing sudden complications of their stones directly from the asymptomatic state. Like other patients, they almost always first become symptomatic. Furthermore, diabetics withstand elective cholecystectomy extremely well. There is neither an increased incidence of surgical complications or death following *elective* cholecystectomy.[5] Therefore, the advice that we provide to the general population to wait until symptoms develop before treating the disease is good advice to the diabetic as well. However, once the disease becomes symptomatic, diabetics are prone to developing complications of cholelithiasis. Furthermore, they withstand these complications less well. Diabetics who develop acute cholecystitis are more prone to perforation or gangrene of the gallbladder. Thus, once a diabetic becomes symptomatic, treatment should be prompt and not delayed because of increased risk of elective cholecystectomy, as there is none. In summary (Table 3) asymptomatic cholelithiasis in diabetics needs no treatment, but symptomatic cholelithiasis requires prompt treatment.

Incidental cholecystectomy (cholecystectomy en passant). Occasionally asymptomatic gallstones will be

Table 3. Gallstones in Diabetics - Summary of Management

Disease Stage	Treatment	Rationale
Asymptomatic	None	- Only 20% ever develop pain - Complications do not occur before pain appears - Elective cholecystectomy in symptomatic patients well tolerated
Symptomatic	Prompt Cholecstectomy	- Once pain appears complications are more frequent - Complications poorly tolerated - Elective cholecystectomy in symptomatic patients well tolerated
Complicated	Prompt Treatment	- Complications poorly tolerated

Table 4. Asymptomatic Gallstones in Patients Having Laparotomy for another Disease - Summary of Management

Patient Group	Management
1. Unstable patient	defer cholecystectomy
2. Local conditions unfavorable for cholecystectomy	defer cholecystectomy
3. Incision far from gallbladder	defer cholecystectomy
4. Prosthetic graft being inserted	probably defer cholecystectomy
5. None of the above	value of cholecystectomy unclear, but not contraindicated

found during the course of investigation for another abdominal problem, such as a disease of the bowel or an abdominal vascular disease. Also, asymptomatic gallstones may be detected for the first time by palpation at laparotomy. Removal of such a gallbladder is referred to as incidental cholecystectomy or "cholecystectomy en passant." What is the benefit of doing cholecystectomy under these circumstances?

Several studies indicate that patients with asymptomatic stones who have abdominal surgery are prone to develop symptoms from their gallstones within 6-12 months of surgery.[6,7] Some reports state that 50% of such patients will become symptomatic. Some patients may even develop acute cholecystitis in the postoperative period within days of surgery. The reason for this very high rate of development of symptoms after surgery is not at all clear. Several authors have advised performing incidental cholecystectomy routinely and even suggest examination of the gallbladder as a part of the workup for any abdominal problem so that incidental cholecystectomy can be done. Several reports indicate that incidental cholecystectomy can be accomplished without morbidity, even in operations for aortic aneurysms in which prosthetic grafts are used, provided that the retroperitoneum is reperitonealized before removing the gallbladder.[8] However, the situation is far less clear now, since two more recent studies have shown increased morbidity in such patients.[9,10]

Currently this is a problem in which no proven right answer exists, but some suggestions can be made (Table 4). Certainly, if one is performing surgery in the lower abdomen, long incisions should not be made in order to take out the gallbladder. Nor should cholecystectomy be done when the patient is unstable or local conditions around the gallbladder make that procedure difficult. Personally, I would not advise incidental cholecystectomy at the present time, in any asymptomatic patient, but particularly in the situation in which a prosthetic graft is being used. One of the reasons for this view is that the management of postoperative acute cholecystitis using percutaneous cholecystostomy is much better now than it was years ago, as is our ability to make the diagnosis of this condition with newer diagnostic techniques. Thus, the morbidity of a complication of gallstones is much less today. Perhaps the most important point about incidental cholecystectomy is that it is important for us to determine why the incidence of conversion from asymptomatic to symptomatic disease occurs in this population and take steps to prevent it. It should be stressed that this advice applies to asymptomatic stones only. If the patient has had biliary symptoms it is wise to remove the gallbladder at the time of other abdominal surgery.

Cancer and gallstones. Chronic inflammation appears to be associated with development of cancer in many areas of the body. Chronic bronchitis, ulcerative colitis, and certain forms of gastritis are also precancerous lesions. Chronic cholecystitis associated with gallstones is no exception to this rule, however, fortunately the risk of developing cancer of the gallbladder in association with gallstones is extremely uncommon. When cancer of the gallbladder arises, it usually occurs in the very elderly. Is prophylactic cholecystectomy to prevent cancer indicated? Analytical studies have consistently shown that the morbidity and mortality of elective cholecystectomy, done in order to prevent carcinoma of the gallbladder, would be greater than the morbidity and mortality of the disease which it was intended to eradicate. This conclusion would probably be correct even today when the operation can be done laparoscopically. Furthermore, the cost of preventing gallbladder cancer by prophylactic cholecystectomy would be prohibitive.

The clinician should be aware of some special situations. Certain populations such as North and South American Indians have an extremely high incidence of carcinoma of the gallbladder.[11] These patients frequently have cholelithiasis also, but the rate of development of carcinoma in the gallbladder is far greater than one would expect based even on their high incidence of gallstones. The reasons for this are unclear; genetic and dietary factors have been suggested. It has been estimated that the incidence of carcinoma of the gallbladder in Indians is greater than the incidence of carcinoma of the lung in a population of cigarette smokers. It may reach 5%. Currently there is no recommendation to perform a prophylactic cholecystectomy in this population. However, it would probably be advisable to follow such patients by ultrasound.

The incidence of carcinoma of the gallbladder in the population in general, as noted above, is low. However, there are some problems associated with a higher incidence of cancer of the gallbladder. The most prominent is the porcelain gallbladder which has been discussed previously. Patients who have stones greater than 3 cm in diameter may have a higher incidence of carcinoma of the gallbladder, although this is unsubstantiated.[12] Individuals who have polyps in the gallbladder measuring more than 1 cm probably should have a prophylactic cholecystectomy because of the chance of these polyps being adenomatous in type. Most polyps of the gallbladder are in fact retention polyps and are a form of localized cholesterolosis. Cholesterolosis itself is not a premalignant condition and needs treatment only if the patient has true biliary colic.

Occasionally a patient with stones will present with an abdominal ultrasound that shows a mass in the gallbladder. Also, the radiologist may report that the gallbladder is unusually thickened. This should be of concern, particularly when one wall is thicker than the other. Under these two circumstances the surgeon should perform an extraserosal resection of the gallbladder, removing the entire gallbladder from the liver bed. Usually during cholecystectomy part of the wall of the gallbladder is left on the liver bed, but here the place of resection should be through the liver. At the present time this can only be done by an open operation. Although this clinical situation is a very uncommon one, it needs to be treated seriously, and as if the patient has a carcinoma of the gallbladder. The extraserosal resection of the gallbladder should be accompanied by complete removal of fat and lymph nodes in the triangle of Calot. One should also be prepared to perform a more extensive local liver resection if necessary.

About once out of every 300 routine cholecystectomies the pathologist reports that an unsuspected carcinoma of the gallbladder has been found in the specimen. Usually the surgeon will have noted that the gallbladder was somewhat thick-walled at surgery and this will have been logically and appropriately attributed to chronic inflammation, which indeed is the cause of thickening in most cases. Two approaches may be taken here. If the carcinoma is completely confined to the gallbladder wall and appears to have been completely resected, then no additional surgical treatment is usually required. If there is a question about this, then one may elect to do a local resection of the serosa of the gallbladder with or without a portion of the underlying liver, or one may use local radiation and chemotherapy. Unfortunately, there is very little information regarding which if any of these treatments is effective, in preventing recurrence.

The safety of laparoscopic cholecystectomy. Laparoscopic cholecystectomy has been a great advance in the treatment of gallstones. However, its introduction has not been without cost. The incidence of bile duct injury is reported to be between 0.5 and 1%.[13] Reduction of this injury to a more acceptable level is a prime goal of the American and international surgical community. It seems that most of these injuries occur early in a surgeon's experience and when the operative technique is pushed too far. The critical requirement in any cholecystectomy is the conclusive identification of the cystic duct and cystic artery, since these are the structures which are to be divided. Failure to identify the cystic duct conclusively and mistaking it for the common bile duct has led to the injuries described above.

It is important to understand the factors leading to difficulty in laparoscopic cholecystectomy and the need for conversion to open cholecystectomy. We have recently conducted an analysis of our first 600 cases in which there were no injured bile ducts and in which the conversion rate to open cholecystectomy was 5%. The following were found to be associated with intraoperative difficulties requiring conversion to open cholecystectomy: older age, maleness, more than 10 attacks of biliary colic, and previous history of acute cholecystitis. Early in their experience surgeons should avoid patients who have a combination of these factors and should not hesitate to convert to open cholecystectomy at any point when anatomy is not clear or vision is impaired, by blood or for technical reasons. Conversion to open cholecystectomy should not be considered to be a complication of the procedure, but a natural outcome and a wise decision when the procedure is difficult. I am aware of prominent hepatobiliary surgeons in the United States who have conversion rates of up to 10%, but who at the same time have had no ductal injuries. If a 10% conversion rate is the price of avoiding ductal injuries, then without question it is a price worth paying.

While ductal injuries have been more common with laparoscopic surgery, other complications have been notably fewer. Of great importance is the fact that respiratory and pulmonary complications, the main complications leading to death in elective cholecystectomy, are very rare following laparoscopic cholecystectomy.[13] The reason for this is that the painful upper abdominal incision, which led to diaphragmatic splinting, atelectasis, hypoxia, and arrhythmias is no longer present. In a series of open cholecystectomies from 1984 to 1989 involving over 600 patients we had no deaths. However, we did have an 8% incidence of postoperative fever, atelectasis, pneumonia, or arrhythmia.[14] In our series of laparoscopic cholecystectomy these complications have almost totally been eradicated. Thus, laparoscopic cholecystectomy has made the treatment of gallstones much safer for the patient who has cardiopulmonary problems or who is elderly or debilitated.

There is no question that laparoscopic cholecystectomy has made the treatment of gallstones much more pleasant for the patient. In fact it is the patient's demand for this procedure which has primarily driven the procedure. It probably has also reduced the overall cost of treatment to the population since patients leave the hospital much more rapidly and return to work more rapidly. On aggregate, the safety of the procedure has probably also increased. However, one cannot ignore the single problem of bile duct injury and stringent efforts are required to continue to reduce this injury to acceptable levels.

Recurrent symptoms after cholecystectomy. Some patients will continue to have symptoms after cholecystectomy or develop new symptoms. An approach to this problem by the primary care physician is very important (Table 5). The commonest cause of post cholecystectomy symptoms is that the preoperative diagnosis of symptomatic cholelithiasis was incorrect. As noted above patients with asymptomatic gallstones can have abdominal symptoms. The commonest problem of this sort is the irritable bowel syndrome. Gallstones are extremely common in our population. In a 60-year-old woman the chance of having gallstones is approximately 25%. The chance of a patient with irritable bowel syndrome who is female and age 60 of having symptomatic cholelithiasis is therefore about 25%. Removal of the gallbladder in such a patient will not help the irritable bowel syndrome and the patient will be left with postoperative symptoms. Thus the main way of preventing postoperative symptoms after cholecystectomy is not to treat patients whose gallstones are not symptomatic, but to make the correct diagnosis in the first place and treat that diagnosis.

A second cause for symptoms following cholecystectomy is the failure to detect and treat bile duct stones. Choledocholithiasis can produce pain identical to biliary colic. Choledocholithiasis should be the presumptive diagnosis when the patient develops postoperative pain. Some presentations, of course, are even more obvious such as when the patient becomes jaundiced or develops pancreatitis. If pain alone exists and it is typically biliary colic, then an ultrasound examination and liver function tests may confirm that the problem is in the biliary tree. The classical ultrasound picture is not that of a stone since stones are difficult to see in the bile duct, but rather of a dilated bile duct. An abnormal liver function test or ultrasound abnormality is an indication for ERCP. If the patient continues to have biliary colic, then even in the absence of abnormal liver function tests or abnormal ultrasound findings, an ERCP is indicated. This test will also determine whether stenosis of the sphincter of Oddi, a very uncommon problem, is present. Stenosis of the sphincter can be dealt with at the same time by papillotomy.

A third cause of postoperative pain is one which I have not previously seen reported, but have observed in my practice on several occasions, namely hypersensitivity to codeine or codeine-containing products. The sphincter of Oddi is sensitive to codeine. When the gallbladder is present, it acts as a bile reservoir. When the sphincter goes into spasm after ingestion of codeine, bile can enter the gallbladder and the biliary tract does not become distended and pain does not result. However, after removal of the gallbladder this situation does not pertain, and the distended biliary tract may give pain. Whenever a patient who has had a cholecystectomy complains of biliary colic, the first question the physician should ask is whether codeine or codeine containing products have been taken for headache or some other unrelated problem. In some cases, such a history will be found and the problem may be simply treated by advising the patient to avoid codeine. Careful questioning of the type of product the patient has taken should be performed, since the patient may be unaware that codeine was contained, as one part of a medicinal compound.

If cholecystectomy has been performed for the correct indications, i.e. biliary colic, and postoperative in-

Table 5. Recurrent Pain after Cholecystectomy - Summary of Management

Pain Type	Management
Biliary	1. Eliminate codeine if its use preceded the pain. 2. If no codeine use do US and LFTs. ERCP for positive results or recurrent biliary pain.
Intestinal	1. GI workup. Rule out organic disease and then treat functional GI complaints.
Incisional	1. Rule out infection, hernia or suture pain. 2. Treat with heat or other forms of energy. 3. Locally applied steroids sometimes helpful.

vestigation of persistent pain shows that the problem is not in the bile duct, then one must look elsewhere in the abdomen for the cause of the symptoms. This often will require a complete gastrointestinal workup.

Table 6. Typical Disabling Biliary Colic* Without Gallstones - Summary of Management

Radiological Findings	Management
1. No stones but sludge present	Follow patient 3-6 months. Perform cholecystectomy if both pain and sludge are persistent.
2. No stones or sludge present	Do Biliary drainage-CCK test. Perform Cholecystectomy for: - >10 cholesterol or bilirubinate crystals per low power field on centrifuged specimen - cystic duct syndrome Consider cholecystectomy for: - hypercontraction - hypocontraction

* These suggestions apply only to patients with disabling and typical biliary colic.

If a cholecystectomy has been done as an open procedure then one must also consider wound pain. Wound pain may be caused by hernias in the wound, by nerve entrapment or infection. Occasionally if nonabsorbable sutures have been used, they may cause irritation, particularly if they have been cut very long and can touch the skin. Such a situation may seem unusual, but it can occur in very thin individuals. Sometimes patients develop incisional pain without any of the above causes. Unexplained postoperative pain is not uncommon after sternotomy or thoracotomy, but is very uncommon after abdominal procedures; nonetheless, it can occur. One should not dismiss such patients as hypochondriacs. This type of pain will often subside with time, but may require additional treatment such as application of heat or other forms of energy. Occasionally injection of such wounds with steroids, especially in the case of hypertrophic scars may be helpful. When the pain is superficial and burning in nature and is aggravated by movement of clothes over the incision, topical steroids may provide some relief.

Whether cholecystectomy itself ever results in residual upper abdominal symptoms as a result of removal of the bile reservoir is unclear. It does not result in pain, but there are unproven claims that it may result in a form of dyspepsia. Cholecystectomy can be followed by diarrhea. Fortunately, this is almost always limited to a three month period, and only affects a small percent of patients. In a very small group of patients, diarrhea will be longer lasting. The genesis of this problem is almost certainly the entry of increased amounts of bile salts into the colon. Treatment is symptomatic and may consist of antidiarrheal agents. Sometimes cholestyramine in moderate doses is effective.

Biliary pain, but no gallstones. Occasionally the clinician is confronted by the patient who has typical biliary colic with the classical features of location, severity, and timing, but who has no evidence of gallstones on ultrasound or cholecystography. Sometimes this pain is disabling. Such patients have sometimes been dismissed as having psychological problems when in fact they have an organic condition that can be cured. There are several conditions capable of giving typical biliary colic, but which are not normally diagnosed by ultrasound or oral cholecystography. Although these conditions are rare, they are worthy of consideration when there is typical disabling biliary colic, but no stones can be seen on conventional studies.

Probably the commonest situation of this type arises when there is sludge in the gallbladder. Sludge is an amorphous collection of solid material, which has not yet congealed into a stone. Sludge is typically composed of mucin, pigment, cholesterol crystals, and other components of bile which are precipitated into a gel-like mass. Tiny stones may be hidden in the sludge. Sludge may be temporary or it may be permanent. Sludge can cause typical biliary colic. Sludge has also been described to cause pancreatitis. Typically, sludge occurs during prolonged periods of fasting or during pregnancy when the motility of the gallbladder is reduced. Steps which increase the motility of the gallbladder during fasting will prevent the formation of sludge.

Should a patient present with typical biliary colic and sludge, I suggest the following approach (Table 6). The patient should be informed that they have sludge, but no stones. Such patients should be followed for several months. If the pain and sludge are both persistent then cholecystectomy should be considered. In most cases the sludge will disappear, as will symptoms. One should stress that the symptoms should be typical of biliary colic and not vague dyspeptic symptoms or pain in the lower abdomen or other locations, suggestive of other diagnoses.

There are other gallbladder diseases which cannot be routinely detected by conventional studies. Rarely stones are extremely small and not detectable by either ultrasound or oral cholecystography for technical reasons, such as overlying bowel gas. Cholesterolosis of the gallbladder, a disease in which there is localized or diffuse infiltration of the mucosa of the gallbladder with cholesterol. This problem is usually asymptomatic. However, cholesterolosis may sometimes cause typical biliary colic. Adenomatosis is another disease of the gallbladder sometimes causing biliary colic. In this condition there is benign ingrowth of glands into the wall of the gallbladder. These ingrowths form mucosal pockets, often deep into the muscular layer. The cause of biliary colic in these two conditions is unknown, but it may be due to uncoordinated contraction of the gallbladder.

Small stones, cholesterolosis, and adenomatosis may be diagnosed by biliary drainage.[15] This test is performed by putting a nasoduodenal tube at the ampulla of Vater and injecting CCK octapeptide to cause the gallbladder to contract. The bile specimen which is obtained can be examined for cholesterol or calcium bilirubinate crystals. More than 10 crystals per low power field on a spun specimen is indicative of disease in the gallbladder. Patients who have cholecystectomy under these conditions do very well as we showed a number of years ago.[15]

Dysmotility problems of the gallbladder may rarely also give rise to typical biliary colic. One such condition is referred to as the cystic duct syndrome. In this condition the cystic duct is extremely narrow, probably due to congenital malformation. The gallbladder can fill because this is a slow event taking place over many hours, but when the gallbladder contracts forcefully in response to cholecystokinin, gallbladder pressure rises because of the very narrow outlet and pain results. The greater the stimulus, the greater the pain. Thus, pain is more likely to occur after fatty meals which cause greater release of cholecystokinin. In the cystic duct syndrome the gallbladder takes up the characteristic spherical shape referred to as the "Fighting gallbladder." We have made this diagnosis in a number of patients with gratifying results on cholecystectomy.

Hypertonia of the gallbladder may also be diagnosed using cholecystokinin cholecystography. As in the cystic duct syndrome the patient is given oral cholecystogram dye in a standard dose of cholecystokinin octapeptide. When the emptying rate is greater than 80% over 30 minutes this is highly suggestive of disease in the gallbladder. Toouli also examined hypomotility using the cholecystokinin test and was able to diagnose dysmotility causing pain in a convincing manner.[16] It should be stressed that dysmotility problems of the gallbladder are rare. These tests should not be done in the presence of vague or atypical biliary pain since yields are so low. They should be reserved for the situation in which the patient has typical disabling biliary colic. Then one may expect a 30 to 40% positive rate. The tests for obtaining and examining bile, and evaluating motility can be done simultaneously as a "biliary drainage CCK test." The results of this test in our hands have been very gratifying in this difficult group of patients.[15]

In conclusion, most patients with gallstones disease can be managed quite straightforwardly. Some patients require special consideration related to their stage of disease, special findings on investigation or association problems. Attention to these details will result in treatment when appropriate and the appropriate treatment when it is required.

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The Author

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Lessons Learned & Learning

Catherine Stocklin

This essay is loosely based on my experiences living and working at a children's home, written in response to a lecture on how to classify dysfunctional personalities into categories.

It is 11 a.m. and I am sitting in the examining room watching Jasmine have another pre-natal. She looks at me and asks me if I want to listen to her baby. Of course, I do and we giggle together as I hear the *thud-thud-thud* of a fetus straining to join humanity. I sit down again, listening carefully to everything the nurse says, writing it down as neatly as possible. Idly, I notice Jasmine tracing the cracks on the floor with her sneaker, then looking out the window, now smiling at me happily.

I sigh to myself because I know the smile is a lie. Last night I heard the girls tell her not to hear *them* - that includes me, you know - not to let them take her baby, not to let them take control. We are the enemy, trying to steal what is rightfully theirs. We want to hurt them, take their babies for mysterious reasons (probably money); we don't care.

Jasmine will have to leave the home I work at soon since we don't have facilities for newborns. I have to wonder how this 15-year-old child can care for a baby. She herself has yet to master the fine art of personal hygiene. Does she really know what she's doing?

It's a silly question, really. Of course not; who does? She just knows what she's familiar with, like everybody else. She *knows* this baby will make her happy, love her, make her feel important. To a certain extent, I even think she's right. There's a status in Puerto Rican society that comes to females for having children. She will be recognized as a woman, and a woman with responsibilities and a family. By her own standards, I think she will even be a good mother; she is a kind and gentle person.

I cannot judge these people, so different from myself. It is one thing to discuss philosophically the ills of these other people, as if they are a rare species of bird, giving them long names like *Jamaican-born African-American*, or *Americanized second-generation Puerto Rican* or even *Biggity Uptown-born Wanna Be* (there's two sides of the fence, remember). It is an entirely different matter to hear their voices, to laugh at their jokes, to hold their babies. To realize that we're actually all the same.

If someone is being hurt, there is no doubt: we must intervene. But as far as classifying people into categories, into certain groups that think in a set way as defined by our own narrow, culturally-limited views, I think this is not good in general. It should be used carefully and only in its utility for helping those (like the homeless, the abused, the emotionally needy) that really need it. We must be careful to maintain the **humanity** in our contact with others, realizing that respect and honor are not just for those who look like ourselves, but for everyone. Separate, it has been decided, is in fact NOT equal, and categorization, by its own definition, builds walls of isolation (albeit perhaps only in the minds of the person doing the categorizing) that are certainly more benign than the harsh chasms created in the days of overt racism and culturalism, but just as real.

Jasmine hops into the car and we drive off towards school. She reminds me that she has to eat and suggests *Wendy's*, her favorite. We get to school, she slams the door, and she almost skips her way into the fat, red-brick building. She is happy and unafraid. Yet, as I watch her, I worry. My forehead and nose wrinkle so that my glasses ride up on my face, putting everything around me out of focus.

Suddenly, I see some paper on the floor, smile to myself, and turn up the radio as Whitney Houston suggests to me that the *Children are the Future*. My glasses come back down and things are clear again.

There is no answer, only today. Life will continue no matter what we think of her, so best to embrace each tomorrow only as it comes our way, enjoying the sunshine and sharing it with others. How is it that Jasmine knew this?

I pick up my carefully lettered notes, wave at the bouncing long black hair, and I slowly drive away.

Catherine Stocklin is a medical student at Washington University, St. Louis. Student articles are coordinated by Craig Carmichael, chairman of the Medical Student Section and Mary Vest, the student section's AMA Alternate Delegate.

University of Missouri-Columbia

Dr. Ewigman

Bernard Ewigman, MD, MSPH, associate professor of family medicine is lead author of an article published in the *New England Journal of Medicine* that states routine ultrasound is not necessary for normal pregnant women.

The article reports the findings of the Routine Antenatal Diagnostic Imaging with Ultrasound (RADIUS), a five-year study funded by the National Institute of Child Health and Human Development.

Patients with low risk for childbirth complications were enrolled from 109 ostetrical and family medicine practices, mainly private practice, in six states.

All but two percent of the subjects assigned to the control group did not receive ultrasound exams. Of the experimental group, 94 percent of the individuals received two sonograms, the first between 18 and 20 weeks and the second between 31 and 33 weeks of pregnancy. The rate of adverse outcomes in the ultrasound screening group was 5 percent, compared to 4.9 percent for the control group. Similar numbers in each group delivered prematurely, and the birth weights did not vary between the two groups.

The cost of an obstetrical ultrasound test in the United States averages $188 for the physician's fee, plus an additional fee if the scan is conducted in a hospital or consulting obstetrician's office. The test is often performed two to three times during the course of a pregnancy. Investigators estimate that up to $1 billion a year could be saved if the ultrasound examinations were limited to high-risk pregnancies and problem situations.

Co-authors include **James P. Crane, MD,** professor of obstetrics and gynecology and radiology at Washington University, **Michael LeFevre, MD,** associate professor or family medicine at MU, **Fredric D. Frigoletto, MD,** professor of obstetrics at Harvard, and **Raymond P. Bain, PhD,** research professor at George Washington University, and **Donald McNellis, MD,** RADIUS project coordinator.

St. Louis University

Four major St. Louis health care organizations (Daughters of Charity National Health System, Missouri Baptist Health Care System, St. Louis University Health Sciences Center and SSM Health Care System) and physicians who practice at each, intend to form an integrated delivery network (IDN). The IDN is not a merger, all participating institutions maintain their own identities and ownership. As the network develops, it will negotiate managed care contracts on behalf of participants, develop a unified patient information system, coordinate services among the hospitals to gain economies of scale and increased efficiency, and develop together common measures of quality and network performance.

The Eye Institute that recently opened its doors in a new location, has been named the Anheuser-Busch Eye Institute of St. Louis University in recognition for decades of support by Anheuser-Busch.

Marc J. Shapiro, MD, associate professor of surgery and director of the division of trauma services, has received a one-year grant from ClinTrials, Inc. to compare the effectiveness of two antibiotics, Merrem and Primaxin for the treatment of lower respiratory tract infections or pneumonia acquired during hospital stays.

Peter Zassenhaus, PhD, associate professor in the department of molecular microbiology and immunology has received a two-year grant from the American Heart Association-Missouri Affiliate Inc. to study whether mitochondrial DNA mutations are a predictor of heart disease in patients who have heart transplants.

St. Louis University researchers are looking for volunteers for the following studies:

> The second trial of the drug, dihydroergotamine mesylate (D.H.E. 45), a nasal spray treatment. People who experience between one and six migraine headaches per month but have no history of chronic illness Participants must not be using daily analgesics, daily prophylactic migraine therapies or tranquilizers. Women must not be pregnant or lactating. Contact the department of neurology, (314)577-8026.
>
> Psychophysiological Investigations of Myocardial Ischemia (PIMI), to investigate the causes of the lack of blood flow to the heart, which may trigger abnormal heartbeats and sudden death. 60 volunteers, age 21-80, who have coronary heart disease that has been documented by a positive angiogram. Contact Preventive Cardiology Program at (314)577-8770.
>
> Asthma study of the drug Zileuton, a medication taken in pill form that prevents airway spasms and inflammation from developing. Volunteers over the age of 18, diagnosed with mild to moderate asthma, may contact the division of pulmonology and pulmonary occupational medicine, (314)577-8856.

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NEW MEMBERS

❖ **Paul R. Baily, MD,** 6800 Bannister Road, Kansas City, MO 64134, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Baily received his medical degree at the University of Texas, Houston, in 1985. He completed his residency at Parkland Memorial Hospital, Dallas, TX. Dr. Baily specializes in emergency medicine.

❖ **Daryl A. Lynch,** MD, 2401 Gillham Road, Kansas City, MO 64108, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Lynch received his medical degree at the University of Kansas in 1983. He completed his residency at The Children's Mercy Hospital, Kansas City. Dr. Lynch specializes in pediatrics.

❖ **Mark W. McClung, MD,** 44070 Broadway, #408, Kansas City, MO 64111, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. McClung received his medical degree at the University of Texas, Southwestern Medical School, Dallas, in 1986. He completed his residency at the University of Alabama. Dr. McClung specializes in plastic surgery.

❖ **Randolph A. McKenzie, MD,** 5400 N. Oak Trafficway, Suite 119, Kansas City, MO 64118, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. McKenzie received his medical degree at the University of Tennessee in 1983. He completed his residency at the University of Tennessee. Dr. McKenzie specializes in otolaryngology.

❖ **Jeffery McNabb, DO,** 1435 Mt. Auburn Rd., Cape Girardeau, MO 63701, has become a member of the Cape Girardeau County Medical Society. Dr. McNabb received his doctor of osteopathy at the University of Osteopathic Medicine & Health Sciences, Des Moines, Iowa, in 1990. He completed his residency at St. Louis University. Dr. McNabb specializes in internal medicine.

❖ **Lynn M. Harper-Nimock, MD,** 2525 East Meyer Blvd., Kansas City, MO 64132, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Harper-Nimock received her medical degree at the University of Missouri-Kansas City in 1981. She completed her residency at St. Francis Hospital, Memphis, TN. Dr. Harper-Nimock specializes in family practice.

❖ **Joseph J. Parks, MD,** 1706 E. Elm, PO Box 687, Jefferson City, MO 65102, has become a member of the Boone County Medical Society. Dr. Parks received his medical degree at the University of Michigan in 1983. He completed his residency at Boston University. Dr. Parks specializes in psychiatry.

❖ **R. August Ritter III, MD,** 48 Doctors' Park, Cape Girardeau, MO 63701, has become a member of the Cape Girardeau County Medical Society. Dr. Ritter received his medical degree at the University of Missouri-Kansas City in 1986. He completed his residency at St. Louis University. Dr. Ritter specializes in orthopedic surgery.

❖ **Mark J. Velleck, MD,** 3401 Berrywood Drive, Suite 303, Columbia, MO 65201, has become a member of the Boone County Medical Society. Dr. Velleck received his medical degree at the University of Minnesota in 1986. He completed his residency at Barnes Hospital, St. Louis. Dr. Velleck specializes in internal medicine.

❖ **John J. Wadley, MD,** 1501 S. Grand, Sedalia, MO 65301, has become a member of the Pettis County Medical Society. Dr. Wadley received his medical degree at St. Louis University in 1988. He completed his residency at Indiana University. Dr. Wadley specializes in general surgery.

RESIDENTS

Wayne S. Atebara, MD - *General Surgery*
Andrew Blatt, MD - *Ophthalmology*
Ervin R. Fox, MD - *Internal Medicine*
Jon J. Heeb, MD - *Urology*
Julia J. Lunberry, MD - *Internal Medicine*
Charles V. Nye, Jr., MD - *Internal Medicine*
Paul R. Spence, MD - *Pathology*

STUDENTS

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University of Missouri-Kansas City
Dawn E. Hogge-Adams
J. Matthew Brown
Jonathan Crites
Erica L. Hartmann
Jay C. Helsel
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IN MEMORIAM

■ **Henry C. Bauman, MD,** St. Joseph, Missouri, died May 30, 1993, at age 81. Dr. Bauman received his medical degree at St. Louis University in 1943. He was in private practice in Fairfax, Missouri and at St. Francis Hospital in Maryville, Missouri, for 34 years before retiring in 1972. Dr. Bauman was a member of the American Academy of Family Physicians.

■ **Gail L. Clark, MD,** St. Louis, Missouri, died July 26, 1993, at age 47. Dr. Clark received her medical degree at St. Louis University Medical School in 1974. Before medical school she was a nurse in the coronary care unit at Barnes Hospital. Dr. Clark was a cardiologist and head of the cardiac rehabilitation program at St. Luke's Hospital west in St. Louis County. She was a member of the St. Louis Society of Internal Medicine.

■ **John B. Devine, MD,** St. Louis, Missouri, died July 2, 1992, at age 87. Dr. Devine received his medical degree at St. Louis University in 1930. He was in private practice for 57 years, specializing in lung ailments. Dr. Devine was on staff at St. Mary's Health Center from 1930 until retirement in 1987. He was also a researcher, instructor and consultant at St. Louis University. Dr. Devine was a member of the American College of Chest Physicians and the American Thoracic Society.

■ **Dorothy J. Jones, MD,** St. Louis, Missouri, died July 8, 1993, at age 84. Dr. Jones received her medical degree at Washington University in 1934. She began her career as an assistant in clinic pediatrics at St. Louis Children's Hospital in 1937. Dr. Jones was a pioneer in the treatment of tuberculosis and founded the St. Louis County Children's Chest Clinic in 1950. She was an instructor in clinical pediatrics for 23 years at Washington University. After retiring in 1963, she was appointed chief of outpatient care at Children's Hospital. Dr. Jones taught pediatrics to nurse practitioners in the late 1970s at Washington University and was named an associate professor emeritus of pediatrics.

■ **Paul W. Miles, MD,** St. Louis, Missouri, died August 9, 1993, at age 79. Dr. Miles received his medical degree at the University of Kansas in 1938. He was in private practice as an ophthalmologist for 24 years, retiring in 1978. He was also on staff at Missouri Baptist Hospital. From 1947 to 1954, Dr. Miles was an instructor and assistant professor of ophthalmology at Washington University. He was a past president of the Midwest Division Association for Research in Ophthalmology and a past secretary of the St. Louis Metropolitan Medical Society. In the 1950s, he was an associate editor of the Journal of Ophthalmology for the American Medical Association and an assistant editor of the American Journal of Ophthalmology. Dr. Miles was a member of the American Academy of Ophthalmology and Otolaryngology and the American College of Surgeons.

■ **Orhan M. Ozmat, MD,** St. Louis, Missouri, died August 13, 1993, at age 66. Dr. Ozmat received his medical degree at the University of Istanbul, Turkey, in 1955. He was in private practice for nearly 30 years. Dr. Ozmat was a partner with the Bellevue Radiology Group in for 25 years before retiring in 1985. He also taught radiology at St. Louis University. Dr. Ozmat was a member of the American College of Radiology, the Greater St. Louis Society of Radiologists, the St. Louis Metropolitan Medical Society, and the Radiological Society of North America.

■ **Harry A. Wittler, MD,** Town and Country, Missouri, died August 15, 1993, at age 76. Dr. Wittler received his medical degree at Washington University in 1943. He served in the Army Medical Corps during World War II. Dr. Wittler, a surgeon, was in private practice for 50 years. He was a staff member at St. Joseph Hospital of Kirkwood, Deaconess Hospital, Lutheran Medical Center and Deaconess Hospital West. Dr. Wittler was a former assistant chief surgeon at the old Frisco Railroad Hospital in St. Louis. He was a member of the American Society of Abdominal Surgeons.

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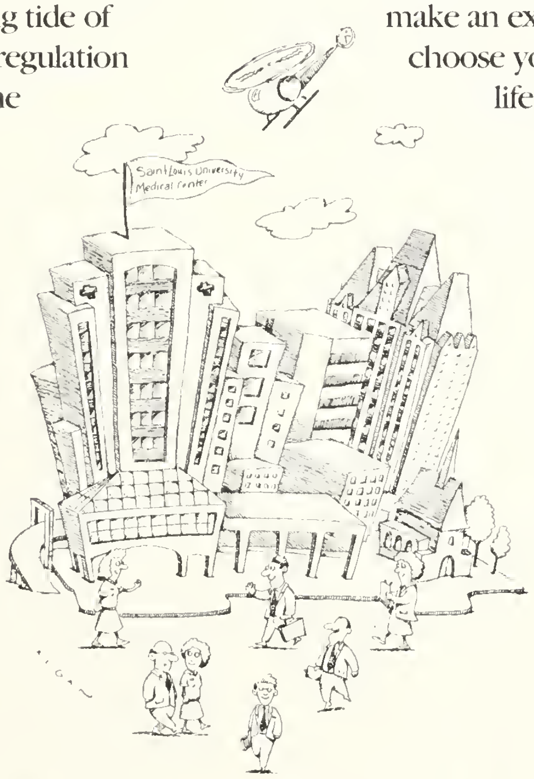
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October

4 to 8 - *St. Louis*: Medicolegal Death Investigator Training Course. 33 credit hours. Contact Mary Fran Ernst, St. Louis University, 314/522-6410, ext. 6509.

6 to 14 - *Belgium*: Allergy Abroad: Holland and Brussels. 17 credit hours. Contact CME, Washington University, 314/362-6893 in Mo or 800/325-9862 interstate.

7 - *Chesterfield*: Oncology Update: Management of Prostate Cancer. 2 credit hours. Contact Carol Broemmer, St. Luke's Hospital, 314/542-4759.

7 & 8 - *Kansas City*: Basic & Advanced Fetal Heart Rate Monitoring Seminars. 12 credit hours. Contact Carol Osborne, CME Office, Saint Luke's Hospital of K.C., 816/932-3737.

8 & 9 - *St. Louis*: Advanced Trauma Life Support Course. 16 credit hours. Contact Mary Keegan, R.N., St. Louis University, 314/577-8365.

8 & 9 - *Springfield*: Pediatric Advanced Life Support Provider Course. 17 credit hours. Call Cox South, 417/885-6111.

8 & 9 - *Walt Disney World Dolphin Hotel, Orlando, FL*: Workshop on Stress Echocardiography. 13 credit hours. Contact Beth Paul, St. Luke's Hospital of Kansas City, 816/932-2301.

9 - *St. Louis*: Modern Keratorefractive Surgery: A Safe, Comprehensive Approach to Radial and Astigmatic Keratotomy. 7 credit hours. Contact Dr. Assil, St. Louis University, 314/577-8264.

9 to 13 - *Arlington, VA*: Gastroenterology Board Review Course. 42 credit hours. Contact Daniel E. Reichard, George Washington University, CME, 202/994-4285.

9 to 13 - *Penatgon City, VA*: Medical Oncology Board Review Course. 38 credit hours. Contact John F. Vargo, George Washington University, 202/994-1791.

11 - *St. Louis*: Wendell G. Scott Lecture: C. Douglas Maynard, MD - A Challenge to Radiologists: The Changing World of Accreditation and Certification. 2 credit hours. Contact Ronald Evens, MD, Mallinckrodt Institute of Radiology, 314/362-7100.

11 to 13 - *St. Louis*: Midas Rex Institute Hands-On Workshop. Contact Midas Rex Institute, 800/433-7639.

12 & 13 - *St. Louis*: Transesophageal Echocardiography Course. 13 credit hours. Contact Dianne Reid, St. Louis University, 314/577-8897.

13 - *St. Louis*: Controversies in Women's Health Care. 7.5 credit hours. Contact St. Louis University, CME office, 314/577-8167 or 800/553-2712, fax #314/577-8214.

14 to 16 - *St. Louis*: Practical Anatomy & Surgical Technique Workshop: Surgical Approaches to the Skull Base. 24 credit hours. Contact St. Louis University, CME, 314/577-8167 or 800/553-2712.

15 - *Kansas City*: Infection Control: Taking Care of the Health Care Worker. 6 credit hours. Contact The Ed Bixby Institute, 816/756-1500, in MO 800/892-5771, ext 4306, bordering states 800/ 821-5140 , ext 4306.

15 - *Chesterfield*: The St. Luke's Cleft Palate Team Approach to the Management of Speech and Hearing Disorders. 6 credit hours. Contact Carol Broemmer, St. Luke's Hospital, 314/542-4759.

16 - *St. Louis*: 2nd Annual Midwest Clinical Molecular Cardiology Conference. 6 credit hours. Contact St. Louis University, 314/577-8167 or 800/553-2712, fax #314/577-8214.

20 - *St. Louis*: Pediatric Advanced Cardiac and Trauma Support for Life/Pediatric Advanced Life Support Recertification Course. 7 credit hours. Contact Mary Beth Foerstel, St. Louis University, CME Office, 314/577-5385.

21 & 22 - *Lake of the Ozarks, Tan-Tar-A*: 12th Annual Missouri Conference on Genetic Disorders. Contact Karen Rhodes, Missouri Institute of Mental Health, 5400 Arsenal, St. Louis, MO 63139, 314/644-8803.

22 - *Springfield*: ACLS Recertification Course. 8 credit hours. Call Donna Willoughby, Cox South, 417/885-4117.

22 & 23 - *Chesterfield*: 7th Annual Symposium and Workshop on Gynecologic Endoscopy: Advances, Complications and Controversies. 12.5 credit hours. Contact Carol Broemmer, St. Luke's Hospital, 314/542-4759.

23 - *St. Louis*: A Practical Approach to Prevention. Contact St. Louis University, CME, 314/577-8167 or 800/553-2712.

24 to 27 - *Raleigh/Durham, NC*: 15th Annual Society for Medical Decision Making Meeting. 21 credit hours. Contact Maria Gorrick, 202/994-8929.

29 - *Teaneck, NJ*: Frontiers in Ovulation Induction. Contact CME, Washington University, 314/362-6893 in MO or 800/325-9862 interstate.

November

3 - *St. Louis*: Updates in Psychiatry/Psychotherapy. 3.5 credit hours. Contact St. John's Mercy Medical Center, 314/569-6290.

4 to 6 - *Kansas City*: Kansas City Southwest Clinical Society's 71st Annual Fall Clinical Conference. Contact Linda F. Smutz, 816/523-3383.

5 & 6 - *St. Louis*: Allergy Update. Contact St. Louis University, CME office, 314/577-8167 or 800/553-2712.

8 to 10 - *St. Louis*: Practical Anatomy and Surgical Technique Workshop - Approaches to Cranio-Cervical Fixation. Contact St. Louis University, 314/577-8167 or 800/553-2712.

8 - *St. Louis*: City-Wide Radiology Conference: John V. Crues, MD - MRI of the Shoulder. Contact R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology, 314/362-7130.

10 to 12 - *St. Louis*: Pediatric Advanced Cardiac and Trauma Support for Life/Pediatric Advanced Life Support Provider Course. 20 credit hours. Contact Mary Beth Foerstel, St. Louis University, CME Office, 314/577-5385.

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How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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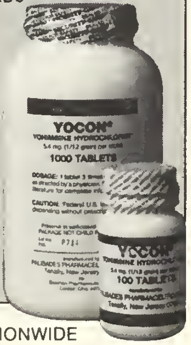

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Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991,14:146-151.

PRAVACHOL® (Pravastatin Sodium Tablets)

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life (t1/2) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin*, *antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine*, *nicotinic acid*, or *probucol*, no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced (p<0.004) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose (p<0.01). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls (p<0.05). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*, a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells, and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter^2). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated, adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy, this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class

Skeletal. myopathy, rhabdomyolysis.

Neurological dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma, anorexia, vomiting

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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Missouri Medicine

Journal of the Missouri State Medical Association

November 1993

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- ❑ Dermatology Quiz #8

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November Cover

Larry Jennings works at The Ovid Bell Press Inc. in Fulton, Missouri where *Missouri Medicine* is printed. Mr. Jennings is a self-taught artist . He began painting at age 25, but put his art on hold while beginning a family. In 1991 he was able to return to his artwork.

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Does Anyone Know Where We Are?

J. Regan Thomas, MD

You may realize that this column is written a month or more before it is published. At this point, anything one might write about Health Care Reform could be completely outdated by the time you receive your copy of *Missouri Medicine*. That's part of why most of us feel lost when we really try to analyze President Clinton's plan. Daily changes, confusing contradictory reports, and ongoing national debate allow the rumor mills to have enhanced credibility in a scenario where no one really knows where we are.

. . . the 'handwriting' on the wall (Clinton's Health Care Plan) is not entirely legible at this time. Someone keeps changing it every few days anyway.

One concept does seem clear: the President's plan will not be enacted as proposed. A long, at times perhaps confusing, debate has only just begun. My office is inundated with applications for new provider plans, multiple overlapping PHO's and health provider "network" opportunities. All my hospitals seem to be joining or developing "alliances" and initiating joint operating relationships. Most of this activity is presented as a response in anticipation of the President's plan. My problem is likely the same as yours. I don't know what the plan is at this point. Is it wise for me as an individual to anticipate significant change before those changes are clearly defined. Some admonish those of us in this situation to read the "handwriting" on the wall. Unfortunately that handwriting is not entirely legible at this time and someone keeps changing it every few days anyway.

The goals of the plan are laudable and include providing health coverage for all Americans and reducing growth in health spending through a system of competitive market forces. A new regulatory agency, the national health board, is suggested to oversee and administer the new system. The preliminary plan suggest key areas, including "universal" insurance coverage, local health networks or health plans, health insurance allowances (insurance purchasing pools), spending limits or caps (global budgets), liability reform (attorney's fees "limited" at 33 $^1/_3$%), and an emphasis on primary care.

The debate, or actually the negotiating process, now begins. The difficulty remains however, that none of us can respond or anticipate changes in our own practice environment with an adequate data base. The most recent review of the plan by the AMA notes that there are certain to be significant changes in the President's proposal. Accordingly, they state, "...how the Clinton plan ultimately affects physicians is likely to vary from that outlined."

It seems that the prudent individual may wish to avoid hasty changes or involved entanglements in a setting as volatile as the present health reform situation. The only thing we can absolutely count on at this point is an inevitable change in the status quo. It merits close observation, and more importantly active participation and input by the medical community.

We must be the strongest voice in the changes to come protecting the quality of care for our patients. The security of the physician-patient relationship is the cornerstone of that quality and it must be safeguarded. In the meantime, stay informed, voice your opinions and advice to our legislators and physician leadership. Whenever you think you know where we are, please tell the rest of us.

LETTERS TO THE EDITOR

Dear Dr. Hagan:

I enjoyed your recent article, "The Name Game..." in *Missouri Medicine*. For a number of years I have been chairman of the alumni interviewing committee for Tufts University in this area and have frequently dealt with the issues that you raised. Of course by the time I see most students it is too late for them and their families to be considering the issues that you raised. I hope to be able to pass your article on to my friends who will benefit from your advice and experience.

Congratulations on an excellent essay.

Sincerely yours,
Andrew B. Kaufman, MD, ***Kansas City, Missouri***

Dear Editor:

Many physicians and/or their spouses wrote and called for additional information about my article on the college admissions process (*Missouri Medicine*, September 1993). I wanted to provide some additional newly available material.

The October 4, 1993 issue of *U.S. News & World Report* has the newest rankings of the 450 largest colleges and universities. The Top Ten rated national universities: Harvard, Princeton, Yale, M.I.T., Cal Tech, Stanford, Duke, Dartmouth, U. of Chicago and Cornell. The Top Ten rated national liberal arts colleges: Amherst, Williams, Swarthmore, Wellesley, Pomona, Bowdoin, Haverford, Middlebury, Smith and Wesleyan. Reprints of the rankings and associated articles are available by writing: Best Colleges, *U.S. News & World Report*, 2400 N Street, N.W., Washington D.C. 20037. ($1.25 per list; 5 list minimum). Bulk rates are available.

A new computer software program, **U.S. News College Planner**, enables students to develop their own educational profiles and match them with the rated 450 schools. The software costs $49.95 plus $5.95 for shipping. It can be ordered by calling (800)437-8600 or writing *U.S. News & World Report*, c/o Sisk Fulfillment Services, PO Box 4770, Federalsbury, MD 21632-0470.

College Counsel is a computerized service that helps applicants select schools and determine if they are eligible for any scholarships. Information is available by calling (800)866-3732 or writing to 220 N. Main Street, Natick, MA 01760.

John C. Hagan III, MD, ***Kansas City, Missouri***

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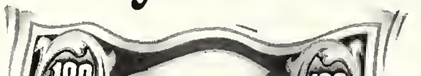

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You mean all of this is over five bucks?

Melvin C. Kasten, MD, MSMA President

I talked to a fellow who quit his doctor, even though he and his family had received excellent care from that physician for several years. My friend and the doctor did not part company over a treatment regimen or a question of diagnostic skill, but rather because the patient believed that his doctor was over charging him five bucks on every visit.

> **We are living in a medical version of "Catch-22." At a time when Americans can receive the finest health care available in the world many feel they can't afford to use it.**

This five dollar fee covered "sterilization" expenses. It was in addition to the normal office visit charge.

The patient was told that the doctor needed to charge an extra $5 to recover his expenses caused by the new OSHA regulations, i.e. the cost of disposable gloves, masks and other protective clothing and the rapid wear on delicate instruments caused by frequent autoclaving.

This alarmed the patient. He's a salaried guy whose pay increases have barely kept pace with inflation in recent years while his deductible and co-pay rates had increased for his company's health care insurance program. At the same time, his plan's coverage had been decreased and, since he'd had a serious illness the year before, he knew that he probably would not be able to change jobs due to his pre-existing condition.

An add-on charge, even a small amount like $5, fanned his feeling of vulnerability about the rising cost of health care.

These ideas stayed in the background most of the time, but boiled to the surface every time he paid a visit to his doctor and paid that extra fee. He knew he was receiving excellent care, but still it soured his stomach as he wrote the check.

Finally, the fellow had enough. He left his old physician and found a new one. And, he began to listen with approval as he heard Hillary Clinton and others describe their health care plan to Congress and the media.

He thought the idea of the government providing more health care coverage for less money sounded like the same old Washington poppycock. But, even though the details were sketchy at best, he liked the basic theme of controlling the increasing cost of his medical care.

Straight talk between the doctor and the patient about fees and the true cost of providing care might eliminate scenarios such as the one I've just described. Why don't we do a better job of explaining our charges and fees? We know our patients are interested in money issues. Every poll tells us that Americans are worried about the upward spiral of medical costs and the impact that it is having on the quality of their lives.

They are so concerned, in fact, that many of them are afraid to visit us - not because we might prescribe an onus treatment, but because the cost of medical care might drain away their life savings. We are living in a medical version of "Catch-22." At a time when Americans can receive the finest health care available in the world many feel they can't afford to use it.

The President and Mrs. Clinton and members of the Congress may not agree on a plan this year or next, but some kind of universal health care is on its way. As a nation, we have reached the point where the majority of Americans believe that affordable health care is a "right" due to every citizen.

I think physicians agree to a large extent. Money issues should not separate a patient from a physician's care.

Physicians deserve fair pay for the care that we provide. First, we must correct erroneous ideas about our fees and the true costs of providing medical services. If that means sitting down with every patient to explain why we charge what we charge, so be it.

Knowing the true cost of care may be as helpful and necessary to patients today as their informed consent for the suggested course of treatment. Otherwise, we can expect to see the continued seduction of our patients by those outside the medical profession who promise to banish the patient's money worries. Yes, all of this is over five bucks. ■

Alliance Health Promotion

Beverly Murrell, MSMAA Vice-President, Health Projects

The Missouri State Medical Association Alliance and its component county groups follow the lead of the national AMA Alliance Health Promotion Committee and focus in 1993-94 on three goals: preventing family violence, promoting adolescent health and filling needs at the grassroots level. These are some of the projects scattered about the state:

Jasper County members address violence this year by volunteering at Lafayette House, a home for abused women and children. They also distribute "Yellow Pages for Youth" and provide help for the Ozarks Residential Center for Children ages 13-17.

Greene County repeated its summer program for four and five year olds, this time under a new name: "Healthy Kids' Class." The children and their parents are introduced to doctors' instruments, scales and the five senses and to healthy life style incorporating exercise and nutritional ideas. The county Alliance also repeated "Chrysalis," the junior high health fair.

Clay-Platte continues last year's project, producing and distributing wallet-size prescription cards on which patients may list their medications.

Cole County plans an April Breast Cancer Awareness project, providing hospital mammograms at a reduced price, along with educational materials.

The **Boone County** Family Health Center completed its first year of operation in the summer. A collaborative effort of state and county health departments and of the three major hospitals in Columbia, this unique comprehensive primary care center targets the uninsured/underinsured families in Boone County who have no primary health care providers and may use emergency rooms for access to primary care.

The center is staffed by two part-time, board-certified family practice physicians; a family nurse practitioner, and a public health nurse clinician. Eighty physicians have signed up for referrals.

In its first year of operation the clinic served 1,663 patients, with over 3,000 visits. Most patients are white females in the 18 to 44-year age group; others include a significant number of males (38%) and minorities (31%). The clinic also provides services to community agencies such as Rainbow House, Head Start, McCambridge Center for Women, and the Juvenile Justice Center.

Sixty-five percent of patients are self-paying; the remainder are Medicaid-eligible. No one is turned away because of inability to pay. Fees are on a sliding scale based on household income. The average collection from a self-paying patient is less than $10 per visit, although the average charge per visit is at least $40. The patient who helps to pay for his own care is, the clinic and its advisory board feel, a responsible consumer.

Visits incorporate preventive medicine: immunizations, instruction in healthful life styles, and identification of patients at risk.

The Boone County Medical Society Auxiliary under Health Center Project Chairman Jennifer Husain helped to set up this clinic, providing office and waiting room carpet and furnishings, and continues to fund appliances and other items needed from time to time. The group also provides volunteers as needed for nurses and clerical work. It now is a United Way agency.

PROVIDE HEALTH INFORMATION TO YOUR PATIENTS

The *Shaken Baby Syndrome* brochure is an effort to reach every newborn infant's family. It is a simple thing to mention in print that shaking a baby can cause internal bleeding and potential brain damage; it is simple, and just MAY cause someone to think before shaking!

To obtain the brochures for your office or for another appropriate setting, please write to: Marie Williams, Executive Secretary, Missouri Chapter, National Committee for the Prevention of Child Abuse, P.O. Box 531, Jefferson City, MO 65102. Phone: 314/751-5253.

There are several AMAA brochures available, including: *Shape Up for Life* topics on "Drinking and Driving," "Drug Use and Abuse," "Healthy Mother, Healthy Baby," "Child Abuse and Neglect," "Teen Sexuality," and "Teen Suicide."

These and other AMA Alliance materials may be ordered from AMA Alliance Headquarters, 17th Floor, 515 N. State Street, Chicago, IL 60610, or by calling 312/464-4470, or you may contact Beverly Murrell, MSMAA Vice-President Health Projects, 3600 W. Vawter School Road, Columbia, MO 65203.

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Collecting with Class

Danielle Halsel

The Problem

Healthcare has changed dramatically the past few years. In particular, declining reimbursement from many insurance companies necessitates practices look at their financial systems to ensure that everything possible is being done to increase cash flow and decrease accounts receivable. One of the most important aspects of collecting money is to ensure that excellent patient-relations are not compromised.

Obviously, physicians **cannot** increase the amount of reimbursement allowed by insurance carriers; however, it **is** possible to ensure policies are written, and systems are simple and expedient to prevent wasted time following-up on claims.

The generally-accepted "norm" for an accounts receivable is two to two $^{1}/_{2}$ times the average monthly charges, depending on the specialty. Most states have a law stating insurance companies must pay within 30-45 days on any claims not "pending for review"; therefore with the proper systems, practices can be assured of short-term receivables.

The principal cause of a high accounts receivable is failure to collect at the time of service. A written policy definitely increases cash flow and decreases the burden of follow-up on accounts.

The Solution

The following recommendations have been proven effective in medical offices nationwide:

- Develop a written financial policy regarding credit, billing, and collections.
- Discuss the financial policy with patients when they call for the first appointment.
- Include the **entire** staff as part of the collection team; educate and specify duties for each staff member.
- Ensure the patient-registration form includes the following information:
    - *patient demographics;*
    - *guarantor demographics;*
    - *employer name and address;*
    - *primary & secondary insurance names, addresses, ID #s;*
    - *referral names, addresses, phone numbers;*
    - *relative's name, address, phone;*
    - *lifetime assignment of benefits;*
    - *financial agreement;*
    - *release of information*
- Update patient-registration forms annually.
- Request payment at the time of service.
- Call the patient by name.
- State the amount owed.
- Collect the payment.
- Use MasterCard, VISA, and medical credit cards for office and phone collections.
- Provide a return-payment envelope if the patient does not pay at the time of service. Write the patient's name on a follow-up calendar; be sure to follow-up on the appropriate date.
- Send insurance claim forms within 48 hours; use electronic filing if possible.
- Familiarize yourself with the name(s) of the "contact" person(s) at each insurance company; all when you require assistance.
- Fax a copy of a claim to the insurance company if they state they did not receive it.
- Send patient-statements on the 23rd of each month.
- Make phone calls on any account older than 45 days (phone calls are 10-15 times more effective than letters).
- Follow-up on all promises to pay.

Now to begin . . .

1. Hold a staff "team" meeting to discuss the accounts receivable.
2. Set goals and plan strategies (ensure the goal is achievable). If the goal is to decrease the accounts receivable by 25% prior to the end of the year, determine the amount to be decreased monthly.
3. Follow-up meeting to discuss the accounts receivable; set goals and plan strategies (ensure the goal is achievable); and develop a strategy for ensuring increased cash flow. Use the "Collecting with Class Plan" form to determine what should be done; and use the Monthly Status Report to monitor the progress.

---

*If you have questions for Danielle Halsel, write to Practice Management, c/o **Missouri Medicine**, P.O. Box 1028, Jefferson City, MO 65102 or call her at (913)541-0050.*

COLLECTING WITH CLASS PLAN

Date:________________________

Goal:____

Date for accomplishment:____________________

Obstacle(s):____

Solution(s):____

Date:________________________________
Date:________________________________
Date:________________________________
Date:________________________________
Date:________________________________

Results:____

COLLECTING WITH CLASS MONTHLY STATUS REPORT QUARTER____

MONTH:____ Preparation Date____

	ACTUAL COLLECTION	COLLECTIONS GOAL
Week #1		
Week #2		
Week #3		
Week #4		
Week #5		
Average for the month:		
Average for the last month:		
Average year-to-date:		

Physician Comments:____

____

MONTH:____ Preparation Date____

	ACTUAL COLLECTION	COLLECTIONS GOAL
Week #1		
Week #2		
Week #3		
Week #4		
Week #5		
Average for the month:		
Average for the last month:		
Average year-to-date:		

Physician Comments:____

____

MONTH:____ Preparation Date____

	ACTUAL COLLECTION	COLLECTIONS GOAL
Week #1		
Week #2		
Week #3		
Week #4		
Week #5		
Average for the month:		
Average for the last month:		
Average year-to-date:		

Physician Comments:____

____

Dermatology Quiz #8

This 45-year-old lady trucker had a 10-year history of a recurrent itchy, scaly dermatitis on her lower back, buttocks, left wrist, and right axilla. She used various topical medicaments including hydrocortisone cream, clotrimazole (Lotrimin), and triamcinolone cream as prescribed by her doctor. The triamcinolone cream seemed to work best, but the rash persisted and new intensely pruritic lesions developed. She came in for worsening of her condition after she and her husband, who is also a trucker, returned from the west coast.

Her health was good except for diabetes mellitus. She had no known allergies and was using Micronase 2.5 mg Q.D.

On exam, this eruption was noted (figure 1) and she was referred for further evaluation.

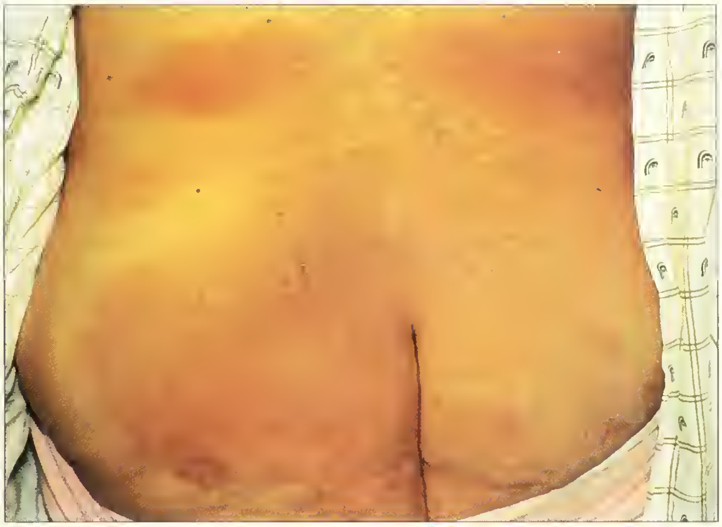

Figure 1

1) The one best clinical diagnosis for her problem is:

a. chronic contact dermatitis.
b. tinea corporis.
c. mycosis fungoides.
d. erythema (chronica) migrans.
e. psoriasis.

2) The best test(s) to confirm your diagnosis may be:

a. allergy patch tests.
b. potassium hydroxide preparations for fungus.
c. skin biopsy.
d. serology for lyme disease.
e. no tests, but a trial of steroids.

(See Answers on next page.)

DERMATOLOGY QUIZ ANSWER

(Dermatology Question is on previous page.)

Answers:

1) c - mycosis fungoides.
2) c is definitive
(b is valuable to exclude a fungus)

"Mycosis fungoides (MF)" has been a curiosity to dermatologists since the early 1800s when the French dermatologist Jean Louis Alibert first described a patient with a chronic scaly rash which later developed "mushroom-like tumors." Later in that century, the disease was categorized into 3 stages: patch (pre-mycotic), plaque (infiltrative) and tumor (nodular) stage. By 1900 an erythrodermic variant was recognized, and in 1938 Sezary found atypical cells in the peripheral smear. It wasn't until 1973 that Edelson and colleagues characterized the infiltrates as T lymphocytes. We now know the MF is an uncommon cutaneous T-cell lymphoma (CTCL) comprised of a malignant clone of helper T-cells (CD_4+) which have an affinity for the skin.

The incidence of this lymphoma appears to be rising, but the underlying etiology is still unknown. A more aggressive adult T-cell lymphoma involving skin has been linked to the virus, HTLV I which opens the possibility of a viral etiology for CTCL. Another etiologic theory in the past has been that MF is induced by chronic contact dermatitis from chemical exposures, but this is unproven. Approximately 7,500 to 10,000 cases per year has been projected in the United States for MF.

The early clinical lesions may appear very subtle and begin as pink to red, scaly patches which may be single or multiple. They may wax and wane or respond to simple measures like topical corticosteroids or sunlight. The initial biopsy may show only a nonspecific dermatitis and thus several more samples over time may be needed. Eventually, the patches become more indurated, infiltrated red-purple plaques and then tumors may evolve. It is possible to form tumors on normal skin (tumor d'emblee variant).

Another variant of MF is to involve the entire skin, causing the "red man" syndrome. This erythrodermic variant usually presents de novo and may have abnormal circulating Sezary cells. These patients can have uncontrollable pruritus, ectropion, and palmoplantar fissuring.

CTCL progresses to involve peripheral then central lymph nodes and viscera. Prognosis depends on stage of involvement and presence of adenopathy. Early stage I disease without adenopathy has a median survival of approximately 12 years, however patients with palpable adenopathy have a median survival of only 40 months.

Treatment also depends on the stage of the disease. In early disease, topical nitrogen mustard, topical nitrosurea (BCNU), electron beam, or psoralens, plus UVA (PUVA) can control the problem. Topical steroids, UVB, and oral retinoids (Accutane, Tegison) are also used. For the erythrodermic or Sezary syndrome, extracorporeal photopheresis has been shown to induce remissions and even presumed cures in a few patients.

The most challenging type to treat is the tumor stage disease with multiple ulcerated, necrotic tumors which may become secondarily infected. Systemic chemotherapy using various agents including chlorambucil, methotrexate, cyclophosphamide, prednisone, has yielded some success. Newer agents like deoxycorformycin, 2-CDA (2-chloroadenosinc) and interferon alfa-2A are being investigated.

The principal objective is to control the disease because the attempt to cure is not rewarded. It is clear that early aggressive therapy with radiation and chemotherapy does not improve long term survival as compared with conservative care using sequential topical regimens. The disease may be indolent and present for years with patients dying from causes other than their lymphoma.

References

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Sausville EA, Eddy JL, Makuch RW, et al. Histopathologic staging at initial diagnosis of mycosis fungoides and the Sezary syndrome. *Annals Int Med* 1988;109:372-382.

Weinstock MA, Horm JW. Population-based estimate of survival and determinants of prognosis in patients with mycosis fungoides. *Cancer* 1988;62:1658-1661.

Submitted by Susan Zurowski, MD, Assistant Professor, Division of Dermatology, University of Missouri-Columbia and Co-Director, Photopheresis Unit, Ellis Fischel Cancer Center.

The Dermatology Quiz is coordinated by Philip C. Anderson, MD, Professor and Director at the University of Missouri in the Division of Dermatology.

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PERSPECTIVES

Health Reform: License to Kill

P.J. O'Rourke

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I can't seem to learn anything about President Clinton's health-care reform plan. I watch the network news and discover that the plan cannot be summarized briefly. I read the papers and find the plan cannot be explained at length. I listened to the president himself and he seems at least as confused as I am, though less succinctly.

I also don't know why I'm supposed to take health advice from a man with an obsession with french fries, a waistline like Beautyrest mattress, the jogging pace of a beached sea lion and the sleep habits of a teenage slumber party.

I gather, from the president's sales pitch, we're supposed to come up with a large sum of money to invest in a vaguely described deal that's going to have a huge payoff someday. Isn't the FCC trying to crack down on people who do this sort of thing over the phone?

But our ignorance of the Clinton health-care plan is of little import. Understanding government programs is like looking at photographers' models or being run over by trucks. Form is more important then content. The bare outline of the plan is so thick, detailed specifics to come, that you can stand on it to paint the ceiling. In my copy of the World Almanac, the U.S. Constitution and the Bill of Rights occupy 4 $^1/_2$ pages. That's 4 $^1/_2$ pages to run an entire country for more than 200 years and half a ream of federal regulations if I slam my thumb in the car door.

It Won't Work

Of course I haven't read this health-care reform plan outline. I suspect Ira Magaziner has "read" the document only in the sense that you and I "read" the book of instructions that comes with a basement dehumidifier. Plus it hasn't been released to the public. And, anyway, says the president, this might not be the real or final plan because he's an open-minded guy and wants to be bipartisan and hasn't had a chance to get everybody's input. Roger Clinton may have some bright ideas. Socks may, too. Though the plan does not cover veterinary expenses. Yet.

We can, however, be certain of some facts about the health-care reform plan. It won't work. No government proposal more complicated than "This note is legal tender for all debts, public and private" ever works. And that doesn't work. Health-care reform hasn't even started and it isn't working. The administration's first step was to present the nation with hundreds of pages designed to reduce paperwork. The plan won't work and will be expensive. All comprehensive government entitlement programs grow vastly larger and more costly than they were meant to be. Witness Medicare, Medicaid, FDIC and so forth. And the one time our country *did* have a comprehensive government entitlement program that was cheap - the Homestead Act - it involved the death or exile of nearly all the native people on the continent.

Our health-care system is too complicated and expensive. So, to fix it, President Clinton is proposing the most complicated and expensive piece of legislation in our nation's history. There is a much simpler way of making American medical treatment less expensive. Just make it worse. And this, too, can be accomplished under the Clinton plan.

Federal health-care reform will drive the best people out of the health-care professions. What type of person is going to become a doctor, a nurse, or, for that matter, a health-insurance executive just to wind up as a bureaucratic goat or government hack? Students with straight A's can get more entrepreneurial freedom (and cheaper health-care benefits) washing windshields at the entrance to the Lincoln Tunnel. There will come a day when you'll be wheeled in for a heart bypass operation and the surgeon will be the same fellow who's now behind the counter when you renew your car registration at the Department of Motor Vehicles.

But let us not forget the moral dimension of the health-care reform. Everyone, rich and poor, needs health-care to live. And everyone, rich and poor, needs food to live. Therefore, next year, the Clinton administration will introduce legislation mandating federal preparation of all our meals.

Continued on page 699

Discover The Elegance Of A Hybrid

At first glance, it's the *beauty* of a rose that catches the eye. The vibrant color. The delicately shaped petals. But study it more closely, and its *elegance* becomes apparent—a gentle blend of softness and strength.

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VASERETIC® 10-25
Enalapril Maleate-Hydrochlorothiazide

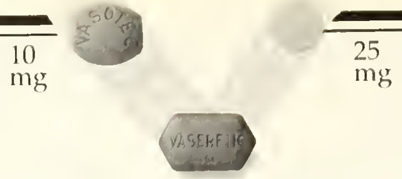
Next

Dosage must be individualized; the fixed combination is not for initial therapy.

Evaluation of the hypertensive patient should always include assessment of renal function.

For a Brief Summary of Prescribing Information, see adjacent pages.

TABLETS
VASERETIC
(ENALAPRIL MALEATE-HYDROCHLOROTHIAZIDE)



> **USE IN PREGNANCY: When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus.** When pregnancy is detected, VASERETIC (Enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, *Fetal/Neonatal Morbidity and Mortality*

CONTRAINDICATIONS: VASERETIC is contraindicated in patients who are hypersensitive to any component of this product and in patients with a history of angioedema related to previous treatment with an angiotensin converting enzyme inhibitor. Because of the hydrochlorothiazide component, this product is contraindicated in patients with anuria or hypersensitivity to other sulfonamide-derived drugs.

WARNINGS: *General, Enalapril Maleate; Hypotension:* Excessive hypotension was rarely seen in uncomplicated hypertensive patients but is a possible consequence of enalapril use in severely salt/volume depleted persons such as those treated vigorously with diuretics or patients on dialysis.

Syncope has been reported in 1.3 percent of patients receiving VASERETIC. In patients receiving enalapril alone, the incidence of syncope is 0.5 percent. The overall incidence of syncope may be reduced by proper titration of the individual components. (See PRECAUTIONS, *Drug Interactions*, and ADVERSE REACTIONS.)

In patients with severe congestive heart failure, with or without associated renal insufficiency, excessive hypotension has been observed and may be associated with oliguria and/or progressive azotemia, and rarely with acute renal failure and/or death. Because of the potential fall in blood pressure in these patients, therapy should be started under very close medical supervision. Such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart or cerebrovascular disease, in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses, which usually can be given without difficulty once the blood pressure has increased after volume expansion.

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis and/or larynx has been reported in patients treated with angiotensin converting enzyme inhibitors, including enalapril. In such cases VASERETIC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis or larynx, likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided.** (See ADVERSE REACTIONS.)

Patients with a history of angioedema unrelated to ACE inhibitor therapy may be at increased risk of angioedema while receiving an ACE inhibitor (see also CONTRAINDICATIONS).

Neutropenia/Agranulocytosis: Another angiotensin converting enzyme inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Lithium generally should not be given with thiazides (see PRECAUTIONS, *Drug Interactions, Enalapril Maleate and Hydrochlorothiazide*).

Pregnancy; Enalapril-Hydrochlorothiazide. There was no teratogenicity in rats given up to 90 mg/kg/day of enalapril (150 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose) or in mice given up to 30 mg/kg/day of enalapril (50 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose). At these doses, fetotoxicity expressed as a decrease in average fetal weight occurred in both species. No fetotoxicity occurred at lower doses; 30/10 mg/kg/day of enalapril-hydrochlorothiazide in rats and 10/10 mg/kg/day of enalapril-hydrochlorothiazide in mice.

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC should be discontinued as soon as possible. (See *Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality*, below.)

Enalapril Maleate; Fetal/Neonatal Morbidity and Mortality: ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function, oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of VASERETIC as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment.

If oligohydramnios is observed, VASERETIC should be discontinued unless it is considered lifesaving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means of reversing hypotension and/or substituting for disordered renal function. Enalapril, which crosses the placenta, has been removed from neonatal circulation by peritoneal dialysis with some clinical benefit, and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure.

No teratogenic effects of enalapril were seen in studies of pregnant rats, and rabbits. On a mg/kg basis, the doses used were up to 333 times (in rats), and 50 times (in rabbits) the maximum recommended human dose.

Hydrochlorothiazide; Teratogenic Effects. Reproduction studies in the rabbit, the mouse and the rat at doses up to 100 mg/kg/day (50 times the human dose) showed no evidence of external abnormalities of the fetus due to hydrochlorothiazide. Hydrochlorothiazide given in a two-litter study in rats at doses of 4 - 5. 6 mg/kg/day (approximately 1 - 2 times the usual daily human dose) did not impair fertility or produce birth abnormalities in the offspring. Thiazides cross the placental barrier and appear in cord blood.

Nonteratogenic Effects. These may include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

PRECAUTIONS: *General, Enalapril Maleate; Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe congestive heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with angiotensin converting enzyme inhibitors, including enalapril, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20 percent of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent pre-existing renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when enalapril has been given concomitantly with a diuretic. This is more likely to occur in patients with pre-existing renal impairment. Dosage reduction of enalapril and/or discontinuation of the diuretic may be required.

Evaluation of the hypertensive patient should always include assessment of renal function.

Hemodialysis Patients: Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes (e.g., AN 69*) and treated concomitantly with an ACE inhibitor. In these patients consideration should be given to using a different type of dialysis membrane or a different class of antihypertensive agent.

Hyperkalemia: Elevated serum potassium (greater than 5.7 mEq/L) was observed in approximately one percent of hypertensive patients in clinical trials treated with enalapril alone. In most cases these were isolated values which resolved despite continued therapy, although hyperkalemia was a cause of discontinuation of therapy in 0.28 percent of hypertensive patients. Hyperkalemia was less frequent (approximately 0.1 percent) in patients treated with enalapril plus hydrochlorothiazide. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with enalapril. (See *Drug Interactions.*)

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Warning signs or symptoms of fluid and electrolyte imbalance, irrespective of cause, include dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, confusion, seizures, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or after prolonged therapy. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia may cause cardiac arrhythmia and may also sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Because enalapril reduces the production of aldosterone, concomitant therapy with enalapril attenuates the diuretic-induced potassium loss (see *Drug Interactions, Agents Increasing Serum Potassium*).

Although any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease), chloride replacement may be required in the treatment of metabolic alkalosis.

Dilutional hyponatremia may occur in edematous patients in hot weather, appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

In diabetic patients dosage adjustments of insulin or oral hypoglycemic agents may be required. Hyperglycemia may occur with thiazide diuretics. Thus latent diabetes mellitus may become manifest during thiazide therapy.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

If progressive renal impairment becomes evident consider withholding or discontinuing diuretic therapy.

Thiazides have been shown to increase the urinary excretion of magnesium; this may result in hypomagnesemia.

Thiazides may decrease urinary calcium excretion. Thiazides may cause intermittent and slight elevation of serum calcium in the absence of known disorders of calcium metabolism. Marked hypercalcemia may be evidence of hidden hyperparathyroidism. Thiazides should be discontinued before carrying out tests for parathyroid function.

Increases in cholesterol and triglyceride levels may be associated with thiazide diuretic therapy.

Information for Patients; Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure, patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

Pregnancy: Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

NOTE: As with many other drugs, certain advice to patients being treated with VASERETIC is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions; Enalapril Maleate; Hypotension—Patients on Diuretic Therapy Patients on diuretics and especially those in whom diuretic therapy was recently instituted, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS.)

Agents Causing Renin Release: The antihypertensive effect of enalapril is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: Enalapril has been used concomitantly with beta adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine and prazosin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: Enalapril attenuates diuretic-induced potassium loss. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia they should be used with caution and with frequent monitoring of serum potassium.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant enalapril and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Hydrochlorothiazide; When administered concurrently the following drugs may interact with thiazide diuretics:

Alcohol, barbiturates, or narcotics—potentiation of orthostatic hypotension may occur.

Antidiabetic drugs (oral agents and insulin)—dosage adjustment of the antidiabetic drug may be required.

Other antihypertensive drugs—additive effect or potentiation.

Cholestyramine and colestipol resins—Absorption of hydrochlorothiazide is impaired in the presence of anionic exchange resins. Single doses of either cholestyramine or colestipol resins bind the hydrochlorothiazide and reduce its absorption from the gastrointestinal tract by up to 85 and 43 percent, respectively.

Corticosteroids, ACTH—intensified electrolyte depletion, particularly hypokalemia.

Pressor amines (e.g., norepinephrine)—possible decreased response to pressor amines but not sufficient to preclude their use.

Skeletal muscle relaxants, nondepolarizing (e.g., tubocurarine)—possible increased responsiveness to the muscle relaxant.

Lithium—should not generally be given with diuretics. Diuretic agents reduce the renal clearance of lithium and add a high risk of lithium toxicity. Refer to the package insert for lithium preparations before use of such preparations with VASERETIC.

Non-steroidal Anti-inflammatory Drugs—In some patients, the administration of a non-steroidal anti-inflammatory agent can reduce the diuretic, natriuretic, and antihypertensive effects of loop, potassium-sparing and thiazide diuretics. Therefore, when VASERETIC and non-steroidal anti-inflammatory agents are used concomitantly, the patient should be observed closely to determine if the desired effect of the diuretic is obtained.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Enalapril in combination with hydrochlorothiazide was not mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril-hydrochlorothiazide did not produce DNA single strand breaks in an *in vitro* alkaline elution assay in rat hepatocytes or chromosomal aberrations in an *in vivo* mouse

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bone marrow assay.
Enalapril Maleate: There was no evidence of a tumorigenic effect when enalapril was administered for 106 weeks to rats at doses up to 90 mg/kg/day (150 times* the maximum daily human dose). Enalapril has also been administered for 94 weeks to male and female mice at doses up to 90 and 180 mg/kg/day, respectively, (150 and 300 times* the maximum daily dose for humans) and showed no evidence of carcinogenicity

Neither enalapril maleate nor the active diacid was mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril was also negative in the following genotoxicity studies: rec-assay, reverse mutation assay with *E. coli*, sister chromatid exchange with cultured mammalian cells, and the micronucleus test with mice, as well as in an *in vivo* cytogenic study using mouse bone marrow

There were no adverse effects on reproductive performance in male and female rats treated with 10 to 90 mg/kg/day of enalapril

Hydrochlorothiazide: Two-year feeding studies in mice and rats conducted under the auspices of the National Toxicology Program (NTP) uncovered no evidence of a carcinogenic potential of hydrochlorothiazide in female mice (at doses of up to approximately 600 mg/kg/day) or in male and female rats (at doses of up to approximately 100 mg/kg/day). The NTP, however, found equivocal evidence for hepatocarcinogenicity in male mice

Hydrochlorothiazide was not genotoxic *in vitro* in the Ames mutagenicity assay of *Salmonella typhimurium* strains TA 98, TA 100, TA 1535, TA 1537, and TA 1538 and in the Chinese Hamster Ovary (CHO) test for chromosomal aberrations, or *in vivo* in assays using mouse germinal cell chromosomes, Chinese hamster bone marrow chromosomes, and the *Drosophila* sex-linked recessive lethal trait gene. Positive test results were obtained only in the *in vitro* CHO Sister Chromatid Exchange (clastogenicity) and in the Mouse Lymphoma Cell (mutagenicity) assays, using concentrations of hydrochlorothiazide from 43 to 1300 µg/mL, and in the *Aspergillus nidulans* non-disjunction assay at an unspecified concentration.

Hydrochlorothiazide had no adverse effects on the fertility of mice and rats of either sex in studies wherein these species were exposed, via their diet, to doses of up to 100 and 4 mg/kg, respectively, prior to conception and throughout gestation.
Pregnancy; Pregnancy Categories C (first trimester) *and D* (second and third trimesters). See WARNINGS, *Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.*
Nursing Mothers: Enalapril and enalaprilat are detected in human milk in trace amounts Thiazides do appear in human milk Because of the potential for serious reactions in nursing infants from either drug, a decision should be made whether to discontinue nursing or to discontinue VASERETIC, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established
ADVERSE REACTIONS: VASERETIC has been evaluated for safety in more than 1500 patients, including over 300 patients treated for one year or more. In clinical trials with VASERETIC no adverse experiences peculiar to this combination drug have been observed Adverse experiences that have occurred, have been limited to those that have been previously reported with enalapril or hydrochlorothiazide.

The most frequent clinical adverse experiences in controlled trials were: dizziness (8 6 percent), headache (5.5 percent), fatigue (3.9 percent) and cough (3.5 percent). Adverse experiences occurring in greater than two percent of patients treated with VASERETIC in controlled clinical trials were: muscle cramps (2 7 percent), nausea (2.5 percent), asthenia (2 4 percent), orthostatic effects (2 3 percent), impotence (2.2 percent), and diarrhea (2 1 percent).

Clinical adverse experiences occurring in 0.5 to 2.0 percent of patients in controlled trials included. *Body As A Whole:* Syncope, chest pain, abdominal pain; *Cardiovascular:* Orthostatic hypotension, palpitation, tachycardia; *Digestive:* Vomiting, dyspepsia, constipation, flatulence, dry mouth; *Nervous/Psychiatric:* Insomnia, nervousness, paresthesia, somnolence, vertigo, *Skin:* Pruritus, rash; *Other:* Dyspnea, gout, back pain, arthralgia, diaphoresis, decreased libido, tinnitus, urinary tract infection.

Angioedema: Angioedema has been reported in patients receiving VASERETIC (0 6 percent) Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis and/or larynx occurs, treatment with VASERETIC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In clinical trials, adverse effects relating to hypotension occurred as follows: hypotension (0.9 percent), orthostatic hypotension (1.5 percent), other orthostatic effects (2 3 percent). In addition syncope occurred in 1.3 percent of patients. (See WARNINGS.)

Cough: See PRECAUTIONS, *Cough*
Clinical Laboratory Test Findings, Serum Electrolytes: See PRECAUTIONS.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.6 percent of patients with essential hypertension treated with VASERETIC More marked increases have been reported in other enalapril experience. Increases are more likely to occur in patients with renal artery stenosis. (See PRECAUTIONS.)

Serum Uric Acid, Glucose, Magnesium, and Calcium: See PRECAUTIONS.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g percent and 1.0 vol percent, respectively) occur frequently in hypertensive patients treated with VASERETIC but are rarely of clinical importance unless another cause of anemia coexists In clinical trials, less than 0.1 percent of patients discontinued therapy due to anemia.

Liver Function Tests: Rarely, elevations of liver enzymes and/or serum bilirubin have occurred.
Other adverse reactions that have been reported with the individual components are listed below and, within each category, are in order of decreasing severity

Enalapril Maleate—Enalapril has been evaluated for safety in more than 10,000 patients In clinical trials adverse reactions which occurred with enalapril were also seen with VASERETIC. However, since enalapril has been marketed, the following adverse reactions have been reported: *Body As A Whole:* Anaphylactoid reactions (see PRECAUTIONS, *Hemodialysis Patients*); *Cardiovascular* Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high risk patients (see WARNINGS, *Hypotension*); pulmonary embolism and infarction; pulmonary edema, rhythm disturbances including atrial tachycardia and bradycardia; atrial fibrillation; hypotension; angina pectoris, *Digestive:* Ileus, pancreatitis, hepatic failure, hepatitis (hepatocellular [proven on rechallenge] or cholestatic jaundice), melena, anorexia, glossitis, stomatitis, dry mouth; *Hematologic:* Rare cases of neutropenia, thrombocytopenia and bone marrow depression. Hemolytic anemia, including cases of hemolysis in patients with G-6-PD deficiency, has been reported, a causal relationship to enalapril has not been established *Nervous System/Psychiatric:* Depression, confusion, ataxia, peripheral neuropathy (e g , paresthesia, dysesthesia); *Urogenital:* Renal failure, oliguria, renal dysfunction (see PRECAUTIONS), flank pain, gynecomastia, *Respiratory:* Pulmonary infiltrates, bronchospasm, pneumonia, bronchitis, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection; *Skin.* Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pemphigus, alopecia, flushing, photosensitivity; *Special Senses:* Blurred vision, taste alteration, anosmia, conjunctivitis, dry eyes, tearing

Miscellaneous: A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia/myositis, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash and other dermatologic manifestations.

Fetal/Neonatal Morbidity and Mortality. See WARNINGS, *Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality*

Hydrochlorothiazide—Body as a Whole: Weakness; *Digestive* Pancreatitis, jaundice (intrahepatic cholestatic jaundice), sialadenitis, cramping, gastric irritation, anorexia; *Hematologic:* Aplastic anemia, agranulocytosis, leukopenia, hemolytic anemia, thrombocytopenia, *Hypersensitivity:* Purpura, photosensitivity, urticaria, necrotizing angiitis (vasculitis and cutaneous vasculitis), fever, respiratory distress including pneumonitis and pulmonary edema, anaphylactic reactions, *Musculoskeletal:* Muscle spasm; *Nervous System/Psychiatric:* Restlessness; *Renal:* Renal failure, renal dysfunction, interstitial nephritis (see WARNINGS); *Skin:* Erythema multiforme including Stevens-Johnson syndrome, exfoliative dermatitis including toxic epidermal necrolysis, alopecia; *Special Senses.* Transient blurred vision, xanthopsia

* Based on patient weight of 50 kg.

For more detailed information, consult your DuPont Pharma Representative or see Prescribing Information.

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Continued from page 698, P.J. O'Rourke

Members of the public have a lot of questions about the president's health-care plan. Will it cost me less? Can I keep my own doctor? If my kid gets an exotic disease can I go broke looking for a miracle cure and then land a big Hollywood movie contract when Junior's hair grows back? We can divine the response to all these queries. As it is with spouses, so it is with government spokespersons (and let us remember Hillary is both): If an answer is more than three words long, it's "No."

Which brings us to Hillary Rodham Clinton herself and the salient point of the health-care reform. The president has put a *lawyer* in charge of making *doctors* cheaper. Next he'll be trying to get our grass mowed for less by calling the plumber to come have a word with the boy who does the lawn.

Ms. Clinton's lawyer-led health-care advisory panel did not, however, just leap in and suggest that doctors start to charge by the minute, conduct physical examinations in front of juries and get paid for doodling on pads of yellow paper. Instead, the panel carefully examined medical practices in a host of other countries that are going broke from excessive social spending.

If Canada's health-care is so great, how come more Americans aren't apprehended at the border trying to sneak into Ontario to get free liposuction? Such comparisons are of limited value anyway. Canada is a sparsely populated nation with a shortage of gunshot wounds, crack addicts and huge tort judgments. What can we really learn from a medical system devoted to hockey injuries and sinus infections caused by trying to pronounce French vowels?

Double Standard?

We can learn, apparently, to fix prices. Price fixing worked so well in the old Soviet bloc. And it's still working with New York City's rent controls. Everyone knows how easy it is to find an inexpensive, nice apartment in a safe neighborhood there. Why is price fixing a public service when the government does it but a crime when we try it as private individuals? Or is it suddenly all right for Hillary Rodham Clinton to hold up a drug store?

President Clinton is attempting to convince the American voters that they're going to be able to get sick cheaply. He's right. Getting sick has always been cheap, often free. It's getting well that costs a whole lot of money. When the price of an item is fixed above market value, there is a surplus of that item - as the Arabs discovered with oil. When the price of an item is fixed below market value, that item disappears - as the Russians discovered with everything. We have here a basic law of economics. The price of health-care will be fixed below market value. And we're all going to die. ■

PHYSICIAN RECOGNITION AWARDS

The Physician Recognition Award is presented by the Missouri State Medical Association and the American Medical Association to physicians who voluntarily complete 150 hours of continuing medical education within a three-year period. Sixty of the credit hours must be earned in Category I programs.

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EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE AMONG MISSOURI CHILDREN

Donald J. Sharp, MD, DTM&H; Ross C. Brownson, PhD; Daniel M. Sosin, MD, MPH; James R. Davis, PhD; Joan C. Wilkerson, BA; Jeannette Jackson-Thompson, PhD, MSPH; and Linda Cooperstock, MPH

Childhood exposure to environmental tobacco smoke (ETS) increases the risk of lower respiratory infections (e.g., bronchitis and pneumonia), exacerbates childhood asthma, and increases the prevalence of fluid in the middle ear. Using self-reported telephone survey data, we examined the attitudes and practices of Missouri residents related to ETS exposure of children. Ninety-five percent of all respondents believed that ETS exposure is harmful to children and the percentage was similar for households with children (96%) and without children (94%). ETS was present in 42% of households and the percentage was similar for households with children (41%) and without children (44%). Childhood exposure to ETS remains a problem in Missouri, despite widespread awareness of the hazards. More active intervention is needed to reduce ETS exposure in the home.

INTRODUCTION

Childhood exposure to environmental tobacco smoke (ETS) has been causally associated with: increased risk of lower respiratory infections (e.g., bronchitis and pneumonia), exacerbations of childhood asthma, and increased prevalence of fluid in the middle ear.[1-3] Exposure to ETS is estimated to be responsible for 150,000 to 300,000 cases of bronchitis and pneumonia annually.[3] ETS also increases the frequency and severity of asthmatic attacks among the 200,000 to 1,000,000 predisposed U.S. children.[3] Although evidence is insufficient to determine a cause and effect relationship, limited data suggest that ETS exposure increases the risk of sudden infant death syndrome.[3,4] ETS exposure appears to cause more noncancer respiratory diseases and disorders among infants and young children than among older children.[3] Finally, ETS is designated as a group A (known human) carcinogen because it causes lung cancer in healthy nonsmokers.[3]

The major source of ETS exposure for young children is in the home.[5] One national study based on data from 5,300 interviews, found that 49% of children ≤ 5 years of age were exposed to ETS in the home.[6] Another recent study found that 60% of young infants had an indicator of tobacco smoke absorption, cotinine, in their urine.[7] Investigators who examined the association between ETS and respiratory illness among children also found a dose-related association between the amount of maternal smoking and illness.[3,8-10] Both the state and national year 2000 objectives include reducing to $\leq$ 20% the percentage of children <5 years of age who are regularly exposed to tobacco smoke at home.[5,11]

In this article, we use 1993 data from the Behavioral Risk Factor Surveillance System (BRFSS) to estimate the attitudes and practices in Missouri households toward ETS exposure of children.

METHODS

The BRFSS was developed by the Centers for Disease Control and Prevention to assist state health departments in the measurement of modifiable risk factors.[12,13] The BRFSS uses a random-digit dialing technique to select adults ($\geq$18 years of age) for telephone interviews.[14] Beginning in the third week of each month, potential respondents in Missouri are called until 126 interviews are completed. Respondents are asked their beliefs and practices about a wide range of behaviors including smoking. Since January 1993, respondents have been asked how many children <18 years of age live in the household.

For our analysis, we considered a household to have ETS if the respondent reported either being 1) a current smoker, or 2) a nonsmoker exposed at home to the smoke from other's cigarettes, pipes, or cigars.[1,6,15] We used the commonly accepted definition of current smoker as a respondent who reported ever having smoked at least

Continued on page 702

Continued from page 701

100 cigarettes and was currently using cigarettes. Nonsmokers included both never smokers and former smokers. Current smokers were asked whether they had been counseled by a physician within the past year to stop smoking. All respondents were asked whether "...exposure to tobacco smoke is harmful or not harmful to the non-smoker's health," and whether or not "...adult smoking in the home is harmful to a child's health."

To examine the potential exposure to household ETS among Missouri children, we analyzed BRFSS data collected from 490 interviews during January 1993 through June 1993 with respondents <55 years of age. This cutoff was chosen to reduce selection bias because older respondents are less likely to have children in the household and are less likely to be smokers. The data were weighted for the respondents' probability of selection as well as to the age-, race-, and gender-specific population counts from the most recent Missouri census.[12,16] SUDAAN, a program for analyzing complex survey data, was used to produce the standard errors of the prevalence estimates.[17] SAS software was used to calculate Z-scores that were compared with a table of the normal distribution.[18,19] This comparison was used to test the statistical significance of the differences between prevalence values in different subgroups. A two-tailed p-value of ≤0.05 was considered statistically significant.

RESULTS

In our study sample of 490 households, 268 (55%) were reported to contain at least one child. The median number of children per household was two.

Most respondents were aware that ETS is harmful to children (Figure 1). However, respondents from households without children were less aware of the harmful effects of ETS to all nonsmokers (p<0.05). Current smokers were less likely to report that ETS is harmful to nonsmokers (p<0.01) or to children (p<0.01) (Figure 2).

Both the prevalence of respondents who were current smokers and the prevalence of ETS exposure were similar for households with children and without children (29% vs. 30% and 41% vs. 44%, respectively) (Figure 3). Fewer than half of smokers from either households with or without children had been counseled by a physician during the past year to stop smoking (40% vs. 33%, p=0.42).

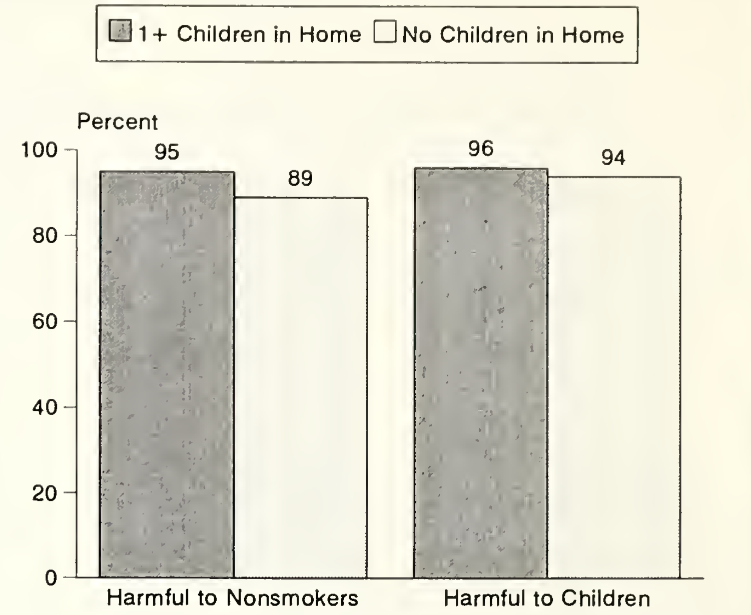

Figure 1. Prevalence (%) in the belief in the harmfulness of ETS to nonsmokers and to children, by households with and without children, Missouri, 1993.

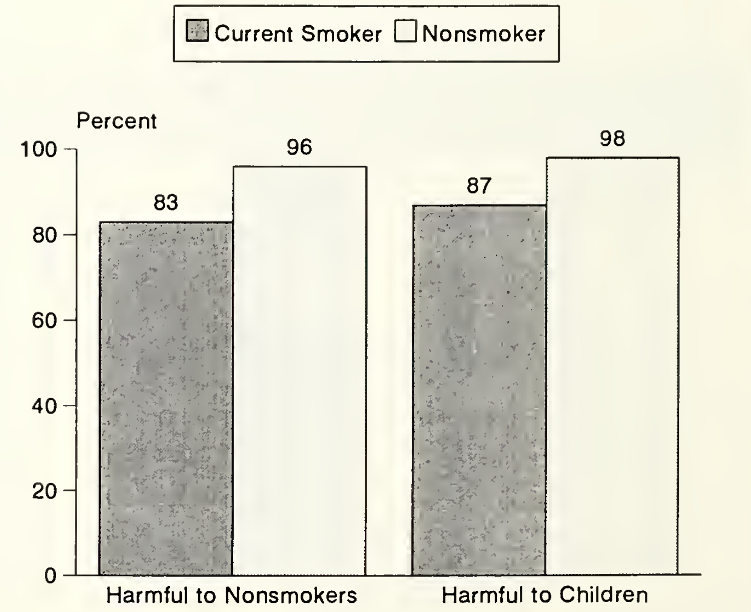

Figure 2. Prevalence (%) in the belief in the harmfulness of ETS to nonsmokers and to children, by smoking status, Missouri, 1993.

DISCUSSION

We found that ETS exposure was present in over 40% of Missouri households with children <18 years of age. Our estimations of both the percentage of Missouri house-

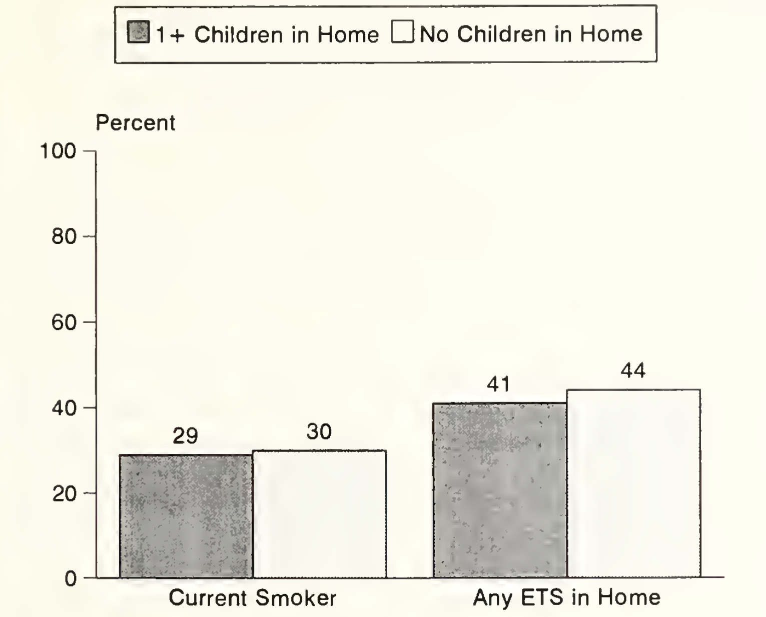

Figure 3. Prevalence (%) of respondent smokers and any ETS in home, by households with and without children, Missouri, 1993.

holds in which a risk of ETS exposure exists, and the percentage of smokers who reported having been counseled to stop smoking during the past year, are consistent with previous studies.[6,7,15,20]

Our study is limited by our inability to assess the amount (dose) of ETS exposure and to look specifically at the youngest children who have the greatest risk of acute respiratory illness from ETS. As a result, our findings may not accurately reflect differences between households with and without young children or the magnitude of this problem in those at greatest risk. However, our results suggest that interventions are needed to reduce childhood exposure to ETS. A program that includes this objective is the 7-year American Stop Smoking Intervention Study (ASSIST) which began its 5-year intervention phase October 1, 1993.[21] Missouri is one of 17 states funded by the National Cancer Institute and the American Cancer Society to conduct the ASSIST project. The overall goal of the project is to reduce the prevalence of smoking from the current 25% to 15%. The ASSIST project has targeted several groups for special attention: 1) children, 2) women of childbearing age, and 3) adults with a high school education or less. Particular emphasis has been placed on the reduction of ETS exposure of children in homes and public places by increasing public and media awareness of the harmful health effects of ETS.[22]

Another ASSIST objective is to have at least 75% of the primary care providers in Missouri perform regular patient counseling about the importance of cessation and to provide support for cessation activities. Studies have shown the cost-effectiveness of physician counseling for chronic disease risk reduction and national recommendations have been established for this activity.[23,24] The presence of children in a household is another excellent incentive to counsel adult patients on smoking cessation and to encourage behaviors which minimize ETS exposure of children. By increasing the percentage of smokers who receive cessation counseling and by educating smokers about the dangers of ETS to children, Missouri physicians can play an important role in the effort to reduce ETS exposure of children.

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COMPUTERIZED MEDICAL RECORDS - NEW OPPORTUNITIES

Robert R. Hausam, MD, J. Craig Klimczak, DVM, and Allen W. Hahn, DVM, PhD

The new generation of computer hardware and software is providing many new opportunities for physicians to use computerized medical records in their practices. A substantial number of new commercial systems have been introduced within the past few years, and many more will likely become available soon. In addition, there are opportunities for physicians to create their own customized systems using new software tools now available.

COMMERCIAL MEDICAL RECORD SYSTEMS

Most or all office medical record needs can be met by one of the newer commercially available systems. Most of these systems are designed to run on IBM-PC compatible or Macintosh hardware, making them relatively affordable to physicians, including physicians in solo or small group practices. Another major advantage of these systems is the use of graphical user interfaces (GUI's), which is becoming almost universal. This type of interface is much easier for the physician, nurse, or office worker to learn and use. Systems using graphical interfaces generally require less time for initial training, and productivity in routine use will likely be increased. The list of available commercial systems and vendors is growing and changing rapidly.

CUSTOMIZED MEDICAL RECORD SYSTEMS

Physicians do not have to wait until standards committees, legislatures or commercial vendors define what their medical records are going to look like.[1] They can create their own customized computerized medical records with new computer data management programming tools. A recent article entitled "Visual Programming Languages" in *M.D. Computing*[2] described several software products that enable non-programmers to create their own applications.

These products fall into two different classes, database management systems (DBMS) and visual programming systems. Database management systems are designed to help users collect and organize data. Programs help the user define the type of data that he or she is collecting and then create the files needed to store the data. Other programs assist in building menu systems, data entry forms and screens, and the data queries. Complete medical record systems have been built using these programs.

Visual programming languages are the latest in software development tools. They allow the user to create graphical user interfaces and data collection systems. A graphical interface is composed of a variety of objects which are selected by the designer and placed in the desired screen location. Objects are items generally found on data entry screens such as buttons, check boxes, text fill-in boxes, and many others. Individual objects are selected from a group of related objects known as a palette. Selection and location of the individual objects are easily accomplished with simple clicks and movements of a mouse or other pointing device. Attractive screens are designed without writing a single line of program code.

A physician might wish to pursue this route to using computerized medical records for several reasons. The use of one of these software tools could allow a physician to experiment with computerized records in his or her own practice at a significantly lower cost than required to purchase one of the commercially available systems. However, the lower purchase cost will be offset to a significant degree by the increased time required to develop and implement the system. For individuals who desire to experiment with the technology and need maximum flexibility, this may be ideal. Other physicians may have major concerns or special needs related to their practice that are not adequately addressed by any of the commercially available systems. These individuals may also benefit from developing their own custom system.

COMPUTERIZED HANDWRITTEN MEDICAL RECORDS

One reason that computerized medical records have not been well accepted is that most physicians do not type. Having handwritten notes transcribed increases the cost and decreases accuracy. Pen-based computers may well eliminate the need for typing.

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Database Management Systems and Visual Programming Languages Available for Personal Computers

Product	Company	Price Range
Database Managers		
Paradox 4.0	Borland International	$450 - $550
DBase IV	Borland International	$450 - $550
R-Base	Microrim	$450 - $599
Fox Base	Microsoft Corporation	$199 - $495
Clipper	Computer Associates	$399 - $499
Visual Programming Languages		
Access	Microsoft Corporation	$199 - $495
Visual Basic	Microsoft Corporation	$199 - $495
Object Vision	Borland International	$99 - $299
CA-Realizer	Computer Associates	$199
Pro-Graph	TGS Systems	$195 - $595
ToolBook	Asymetrix Corporation	$300 - $695

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Apple Computer has just released a new product that uses a pen for data entry on a palm-sized notepad computer called "Newton."[3] Apple's new product comes with many features that could eliminate the need for paper-based records and notepads.

Newton's operating system has the ability to recognize and convert handwritten notes and marks into computer text or commands. The user writes on the screen of the Newton and the computer immediately performs the appropriate conversion. Special areas of the screen are used to select pre-programmed functions. These functions include an address book, phone pad, calendar, scheduler, word processor, and data management system. Built-in intelligence responds to commands like "meet Joe for lunch Tuesday" by entering an appointment with "Joe" onto the schedule. Newton's intelligence allows it to respond to English-like commands thus making it easier to use.

Another promising technology incorporated into the Newton is an enhanced ability to integrate text and graphics. Newton allows freeform note-taking that includes mixing handwritten text, numbers and sketches all on the same page. Handwritten text is recognized and converted into clean type. Sketches can also be converted into clean symbols, diagrams and charts. Physicians can create progress notes on a patient and include diagrams to designate locations of lesions. This increases the scope of computerized medical records over strictly text-based systems.

Wireless communication is another feature found on pen-based computers. The Newton comes with a built-in infrared transmitter which can send information to another computer. This transmitter is of the same type as those found on TV remote controls. Radio-frequency connections are also available. One southern Missouri medical software vendor, **Pal-Med**, is testing pen-based computers on wireless networks.[4] Physicians in a small clinic are using the system to receive medical records and updated lab reports whenever they request them.

The Newton is not the first pen-based computer. Several other pen-based computers have been on the market for a couple of years. IBM, Sharp, NEC, Toshiba, and Grid all have pen-based machines. As governmental regulations requiring electronic medical records increase, more software developers are looking at pen-based computers for physician data entry and retrieval.

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NEXT MONTH

The topic for next month will be systems for bibliographic retrieval and searching of the medical literature.

Prevention - The Forgotten Reform

Nicholas Comninellis, MD, MPH

Almost everyone agrees that America needs a more efficient and equitable health care system. But reforms in these areas alone are not sufficient, for they do little to address the great nation-wide burden of illness that demands expensive care in the first place. Reinforced prevention is the forgotten component in health care reform.

There is false security in relying upon individual behavior change alone to reduce the burden of illness. Instead, we need a broader vision of public health strategy in which key health-oriented policies become law, and are more effective. It is time to call on our President and Congress to uphold their responsibility to protect health through such policies, and thus stem some of the root causes of our crisis.

Hope is growing that significant reform will soon take place in America's health care system. Fueled by such factors as unhealthy lifestyles, high-technology, litigation threats, an increased elderly population, and our depressed economy, the cost of health care continues to rise rapidly. The fall out has been enormous. Medicare and Medicaid continue to cut back on the benefits provided. Employers, hit by higher group insurance rates, are reducing or even dropping health coverage for workers and their families. Premiums for privately purchased health insurance are out of reach of many.

INSUFFICIENT TREATMENTS: THE POPULAR SOLUTIONS

Still, in spite of wide-spread concern and heated debate, there is little nation-wide agreement over how to heal our sick health care system. To date, most reformers have focused on two types of strategies.

The first strategy is to increase health care's efficiency. Paperwork reduction, wider use of co-payments and deductibles, forced limits on use of expensive technology, reimbursement caps, and an expanded role for primary care physicians are just some of the proposed tools. But these are often at odds with our free-market economic philosophy, or with ever-rising professional standards of care. They also tend to envelop us with protocols and regulations that, paradoxically, lead to less efficiency.

The second type of health care reform strategy focuses upon equalizing the distribution of health care dollars and ensuring basic care to more Americans. Mandatory employee health insurance, RVRBS physician reimbursement, and the numerous plans of national or state health insurance are some examples. Yet equality reforms may also bring a host of new problems, such as higher taxes and health care rationing issues.

PREVENTION

Some improvement in access and cost control may result from these reforms. But they ignore the most basic problem behind high health care costs: the great nation-wide burden of preventable illness. Look at what we are spending:

- The U.S. Preventive Services Task Force estimated in 1989 that the total cost of smoking approached $200 billion yearly.[1]
- The economic costs of alcohol abuse, including treatment, lost job productivity, and damage to property, was greater that $115 billion in 1983, the last year for which complete data has been compiled.[2]
- In 1986, health care and lost productivity from cardiovascular disease (largely preventable) cost the United States almost $80 billion.[3]
- The cumulative lifetime medical care costs of treating AIDS patients in the United States is estimated to be $7.8 billion in 1993.[4]

Improving access to efficient, quality care simply is not enough. We must also address the input side of health care demand, and that calls for "upstream" intervention. Yet our prevention efforts are dismal at best. Only four percent of the 1988 total U.S. health care expenditure was for preventions![5] This is an outrage.

Senator Tom Harkin of Iowa summed up our dismal efforts to get at the root causes of the health care crisis:

> "Many of the solutions being offered for the uninsured and underinsured largely represent another pound of cure for a health care system besieged by remedies and quick fixes. Improved access, and even 'free care,' are

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> insufficient to provide the currently-recommended levels of preventive care. Even the often-touted national health care plans of other countries have not translated into comprehensive health promotion programs. It's time for us to put prevention first and develop the sensible principles of preventing disease and disability and promoting health for persons of all ages - at home, school and work."[6]

DOES PREVENTION REALLY PAY?

Some critics contend that prevention actually does not save dollars in the long run. They reason that if a person's life is prolonged through prevention, more dollars will ultimately be spent for care over the lifetime. Thus, no money is really saved. This reasoning, however, fails to account for the many people who suffer or die of preventable illnesses that require years of expensive care. This reasoning also fails to account for the fact that healthy people contribute to the national economy, and ultimately generate health care resources that would otherwise not be available.

Many prevention modalities exist, only some of which are cost-effective. Administration of lipid-lowering agents, for example, has not been found cost effective.[7] Conversely, studies *have* shown the positive financial impact of seat-belt laws, motorcycle helmet use, and education for heart disease reduction.[8-10]

It is difficult to conduct studies that accurately document the long-range financial impact of prevention measures. What's more, we must only look at prevention in terms of financial cost-benefit ratio. Human pain and suffering are also factors that must be considered in the equation of prevention effectiveness.

Ideally studies of cost-effectiveness project the financial impact of prevention interventions on projected lifetime health care costs. Susan Hurley, an epidemiologist at the Cancer Epidemiology Centre in Australia, is one researcher who has conducted such exhaustive studies. Her findings demonstrate lifetime cost-effectiveness of such interventions as exercise programs, mammography, and advice to quit smoking. Other interventions, such as pap smears and antihypertensive therapy, were not shown to be as efficacious in terms of reducing health care costs.[11]

Worksite health promotion programs provide useful evidence on the effectiveness of efforts to reduce illness and insurance premiums. Benefit-to-cost ratios as high as 3.4 were reported, while still accounting for program costs, increased pension liability, health care cost savings, increased productivity, decreased absenteeism, decreased life insurance claims, and program generated income.[12]

The U.S. Public Health Service has repeatedly emphasized the moral and economic demand for aggressive prevention action:

> "Sophisticated technology for the diagnosis and treatment of disease conditions has outstripped society's ability to pay for it. But many of these diseases are avoidable... Mobilizing the considerable energies and creativity of the nation in the interest of disease prevention and health promotion is an economic imperative."[13]

WHO IS RESPONSIBLE FOR PREVENTION?

The emphasis in prevention today is on the individual. This perspective is the cornerstone of *Health People: 2000*, a campaign by the U.S. Department of Health and Human Services. In its report on share responsibilities, the DHHS acknowledges the many influences upon health, and then states:

> "The individual is both the starting point and the ultimate target of the campaign toward *Health People: 2000.* Through the many roles that each us fulfills in our daily lives, we are afforded numerous opportunities for promoting health and preventing disease. With these opportunities, though, comes responsibility, and the first role we must all undertake is responsibility for our own personal health habits. Improving personal health behavior can count among the most potent means to prevent disease and promote health. Measurable decreases in risks to health can result form changes in diet, exercise, tobacco use, alcohol, and other drug use, injury prevention behavior, and sexual habits, but each of us must choose to make these changes a personal priority."[14]

However, the primacy of individual responsibility has not gone without criticism.[15] Not all lung cancer, for example, is due to cigarette smoking. And, changing personal health habits is often difficult and slow. Alcoholism rehabilitation, for example, has long-term success rates of less than 10 percent even in the best hands.

Our environment, as well as our behavior, has a great impact upon health. Robert Crawford emphasized this when he wrote:

> "...social causation of disease has several dimensions. The complexities are only beginning to be explored. The victim-blaming ideology, however, inhibits that understanding and contributes instead to an unrealistic behavior model. It ignores what is known about human behavior and minimizes the importance of evidence about the environment assault on health. It instructs people to be individually responsible at a time when they are becoming less capable as individuals of controlling their health environment."[16]

Through programs such as *Healthy People: 2000* we expect people to change the behaviors causing so many illnesses. But we cling to a false hope if we believe improvements in personal behavior will quickly occur. Is there another approach we are neglecting?

PUBLIC ACTION!

The United States Government is vested with responsibility to protect the welfare of all Americans, and has done so successfully through regulation of housing, food, water, and sewage disposal. It is time to again harness the power of government for health. Through effective public policy we can put desperately needed force into nation-wide prevention efforts. Three such measures should include:

☐ **Significantly increase taxation on tobacco products.** We already know that as tobacco prices increase, consumption drops noticeably. Also, smoking by teenagers seems to be considerable more responsive to price changes than smoking by adults. This is particularly important, since almost all new smokers are teenagers.[17] An increase of 25 cents per pack in California's state tax was implement in 1989, with a documented 5-7% decline in tobacco consumption.[18] An earlier proposed federal tax increase of 16 cents per pack was anticipated to diminish teenage smokers by 17 percent, thus saving 820,000 from tobacco addiction![19]

This strategy is being used effectively in Canada. In the province of New Brunswick, during the Fall of 1991, a single pack of 25 cigarettes cost around $8 (about $7 U.S.). Taxes alone account for $5.57 per pack. With such a high cost for cigarettes, is it any wonder that smoking continues to rapidly decline in Canada?[20]

☐ **Significantly increase taxation on alcohol products.** As is the case of tobacco, drinking goes down as alcohol prices rise. But in spite of this fact, alcohol taxes have not changed substantially in more than 35 years. This in one reason alcoholic beverage prices are relatively less today in comparison with other goods, making them even more available than before. This must change. In numerous studies, even small increases in a state liquor tax results in significant declines in alcohol consumption, illness and death from cirrhosis, and injuries from automobile accidents.[21]

☐ **Mount better organized and funded, nation-wide health education efforts.** Health education to improve personal behavior is one of the most cost-effective means of reducing illness. Yet funding for health education is abysmal.

The recent *Stanford Five-City Project* is a prototype for America. Using multimedia, it promoted healthy diet, blood pressure checks, smoking prevention, weight control, and physical exercise. Significant reductions in plasma cholesterol, blood pressure, resting pulse, and smoking were found in the intervention cities, resulting in decreased total mortality risk scores and coronary artery disease risk scores. And what did all this cost? Only about $4 per person each year - roughly 4% of the annual per capita spending for cigarettes![10]

These are just some of the actions government can take to protect physical health and prevent the need for expensive, curative care. Recent reform of food labeling, and warning labels on alcoholic beverages are welcome steps. Further study is needed concerning the health and economic impact of reduced speed limits, tighter gun control, and mandatory insurance coverage for preventive care services.

But we must also remember, physical health is not an isolated goal. Time and again, researchers show the relationship between poverty and poor health.[22] Whatever we do to break the cycle of poverty, improve employment, balance the federal budget, improve housing, control crime, and provide better education will also contribute to the physical and economic well being of our country.

RESISTANCE AND SPECIAL INTEREST

Strong economic and political interests resist health-oriented policies. We must not allow a few to profit from the destruction of America's health. Some citizens, fearful of any kind of mounting government power, will also resist such actions on principle alone. Yet government sponsored prevention efforts such as these are minute infringement in comparison, for example, with living under the gigantic complexity of a national health insurance system.

Politicians, in general, are reluctant to make major health policy changes because they find it difficult to anticipate the political outcomes. Yet it is just such timidity that allows much needed policies to remain ignored. The missing piece from the American health care picture is emphasis upon cost-effective prevention. Without taking serious steps to decrease our tremendous burden of illness, the crisis in health care will remain and no amount of insurance reform is sufficient. It's time to demand political boldness, and to marshal our government's power to prevent the fires of illness and the flames of financial debt before they burn more uncontrollably.

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Testosterone Pellet Implant Therapy for Lichen Sclerosus

Andy J. Wright, MD

Lichen sclerosus is a benign chronic skin disease predominantly affecting the vulva in post-menopausal women. Various methods of therapy have been recommended for this stubborn and uncomfortable condition. The article describes a new method of therapy for patients suffering from this disorder, utilizing subcutaneously-implanted testosterone pellets to obtain extended remission of symptoms.

Lichen sclerosus (LS) (formerly lichen sclerosus et atrophicus) is a benign chronic condition affecting the epidermis and dermis of the skin. This disease is most commonly seen in women, usually presenting immediately pre- or post-menopausally; but is also seen in prepubertal children and, to some extent, in men. It is most commonly seen in the vulvar and perianal areas, but can be seen anywhere on the body with the most common extragenital sites being on the trunk and limbs.[1]

Genital LS shows symptoms of pruritus and burning, which are usually the presenting complaint. The typical lesion appears as atrophic white papules which coalesce to form placques of "cigarette paper" atrophy.[2] Telangiectasias and subdermal induration are characteristic. Hyperkeratosis of sweat and sebaceous gland orifices are seen on extravulvar sites,[2] the most frequent of which are the flexor surfaces of the wrist and the upper areas of the trunk.

Histologic examination of affected tissue shows variable degrees of thinning of the squamous epithelium with progressive loss of the rete ridges. The dermis has a characteristic acellular homogenous appearance and chronic inflammatory cells are found in a layer just below this homogenous zone. Hyperkeratosis or parakeratosis may be present or absent.[3]

The terminology has changed over the years since this entity was first reported in 1929 under the name kraurosis vulvae. In 1969 Gardner proposed the concept of vulvar dystrophy, which could be divided into hypertrophic dystrophy, characterized by acanthosis and hyperkeratosis; atrophic dystrophy, characterized by thinned epithelium, homogenous dermis, and deep lymphocytic infiltrate; and mixed dystrophy containing foci of both types.[1] The term hypertrophic dystrophy was related to the conditions otherwise known as benign epithelial hyperplasia and lichen simplex chronicus, whereas atrophic dystrophy was synonymous with lichen sclerosus et atrophicus.[3] Most recently the name has been shortened to lichen sclerosus.[4]

The cause of LS has not been demonstrated; however, it is undoubtedly multifactorial. There have been reports suggesting genetic predisposition to the disease; but, in general, statistical significance has been difficult to show. The concept of an association of LS with autoimmune diseases has also been investigated.[2,5] A loss of hyaluronic acid coupled with increased urinary excretion of hyaluronic acid and disappearance of elastic fibers in patients with LS have suggested that an elastase-type protease produced in human vulvar fibroblast may be responsible for many of the physical findings.[1,2] Friedrich and Kabra demonstrated that women with LS had serum levels of dihydrotestosterone well below normal values for their age, whether they were pre- or post-menopausal. Also, their free testosterone levels were elevated, suggesting a block in the conversion of testosterone to dihydrotestosterone. When these patients were treated with topical testosterone, their dihydrotestosterone rose to levels exceeding normal. The enzymatic mechanisms responsible for these findings have yet to be elucidated.[1] The relationship of vulvar dystrophies and LS, in particular, to vulvar carcinomas has been studied by many. The conclusions of such studies have varied widely. The preponderance of literature seems to suggest that the actual incidence of carcinoma developing in association with LS is in the range of 4% or lower. Conversely, LS is often found as an associated lesion in patients with invasive vulvar carcinoma.[1]

At one time vulvectomy was the treatment of choice for LS both to relieve symptoms and to prevent the development of carcinoma. When it was realized that the risk of carcinoma was not as great as originally believed, treatment became more conservative. Corticosteroids have been used in this condition and are often a benefit topically to relieve symptoms. Unfortunately, the use of the stronger fluoridated steroids does not cause resolution of the lesions and may lead to even greater epidermal atrophy than would generally be present with the disease itself.[1] Topical testosterone has been strongly recommended by gynecologic authorities for some time for genital lichen sclerosus. Friedrich stated after review that the literature suggested a 93% response rate to testosterone.[3] This is generally prescribed as testosterone propionate 2% in Vaseline or similar vehicle. This treatment tends to reverse labial architectural changes, relieves pruritus, and restores most of the histologic abnormalities caused by the disease. The drawbacks to testosterone therapy have included the fact that it is not commercially available and must be compounded by a pharmacist. Some patients find that many applications a day are necessary in order to get satisfactory relief. Further, a number of patients will report swelling of the site and burning or irritation when testosterone is originally applied. If this frequent reaction is expected by the patient, it can be tolerated and usually subsides with time. However, a number of patients will interpret this as an allergic reaction and refuse to use the preparation any further. Treatment may need to be administered for up to 6 to 8 weeks before the maximum response occurs. A recent study reports sustained long-term control of resistant cases of LS after 12 weeks of super-potent topical corticosteroid treatment (Clobetasol), followed by p.r.n. treatment with steroids. Contact sensitization to the agent seems to be the main drawback to the therapy.[6]

In my experience the most common presentation of lichen sclerosus is the post-menopausal patient who is having vulvitis. Ordinarily this patient will have been treated in the past for a "yeast infection" or other vaginal infection more than once with no appreciable relief. Often symptoms have been present a number of years. These patients may no longer offer the complaint of vulvar itching, having concluded that physicians cannot help them. Patients who show hallmarks of the disease must, therefore, be asked whether they are having symptoms. Physical appearance of the lesions is not sufficient for making a diagnosis of lichen sclerosus. A tissue diagnosis should always be obtained by vulvar biopsy. Other clinical entities, such as squamous cell carcinoma in situ, squamous cell hyperplasia (hyperplastic dystrophy), Paget's disease and lichen planus may present with similar history and physical findings.[4] Once the diagnosis has been confirmed, treatment can be administered.

My residency training had led me to utilize topical testosterone propionate ointment for all cases of lichen sclerosus. Then, several years into my practice, a patient of mine brought me information about a form of treatment she found superior to what I was doing. While visiting Colorado Springs, Colorado, she had an opportunity to be seen by Dr. Jack Ford. He implanted a testosterone pellet for her and the patient got complete relief of her symptoms for seven months. On her return to my city, she was very insistent that I contact Dr. Ford and learn the details of the treatment method.

In talking to Dr. Ford, he related that he had, for some time, been treating patients receiving post-menopausal hormone replacement with estrogen and testosterone pellet implants. He had noted empirically that patients who had LS improved when they received this particular type of hormone replacement and reasoned that the testosterone component likely brought about the improvement. At that point, he deliberately began to select patients with lichen sclerosus to receive treatment with testosterone pellets and found that this was effective and well tolerated.[7]

I was persuaded to obtain the materials to do the testosterone pellet implant for this particular patient, and first did so in 1987. This patient continued to receive good relief of her symptoms and to prefer this method of treatment above all others. Having gotten good results in this patient, the therapy was offered to others and, as a result, I have accumulated a small base of patients receiving this therapy over the past six years.

PATIENT SELECTION

All patients had biopsy-proven LS prior to being offered this therapy. Patients were initially offered a choice of conventional testosterone ointment or implant, and some patients on oral post-menopausal hormone replacement were also offered the addition of an oral androgen to their estrogen supplement. Some patients received a pellet as their primary therapy, and some came to it after becoming dissatisfied with other methods of treatment.

METHODS AND MATERIALS

Patients were implanted with a single 75 mg. testosterone pellet available from Bartor Pharmaceutical Company in Rye, New York. Implants were done in the inguinal skin. A small skin wheal of 1% Xylocaine with Epinephrine was used and a small incision was then made allowing entry of the trocar. The pellets were displaced about 3 cm. laterally from the incision in hopes of reducing the chance the pellet would work its way back up to the skin closure. Initially the incisions were closed with a single chromic suture; but, at this time, I close the incision with steristrips. The site of implantation is varied to the other side of the trunk each time the patient has an implant. Of a total of 36 implant procedures done, one pellet worked its way back up into the skin incision, resulting in a foreign body reaction with patient removal of the pellet. There were no other complications of insertion of pellets. The pellet insertion sites were not detectable on subsequent examination.

I recently surveyed 15 patients who had received this therapy between 1987 and 1992. Of those patients identified, all had medical records available for review. In addition, 12 of the 15 patients returned a survey form commenting on their experience with the implants. Of 15 patients treated, 87% (13) responded noticeably to the treatment with 33% (5) reporting complete relief and 27% (4) reporting substantial relief of symptoms. Two patients received significant relief of symptoms with the first implant, but did not experience the same degree of relief with subsequent implants. Of those 12 patients responding to the survey, 83% experienced relief of symptoms. Of these responders, 20% experienced relief within one week of the implant, 60% had responded by two weeks, and 40% took greater than two weeks to respond.

An index of patient satisfaction with the treatment method might ultimately be the number of patients returning to request a repeat of the implant. Of those 15 patients treated at the time of the report, 9 patients had multiple implants done, 2 patients had their implant less than six months prior to the study, and 1 patient had not experienced recurrence of symptoms as of 17 months after the first implant. One patient had decided, after the first implant, that she preferred other methods of therapy, although she did respond to the implant. The other 2 patients (20%) were the 2 patients who did not obtain any response to the initial implant. Of the 15 patients, 5 became regular users of the implants, coming in to have their implants repeated once they began to experience symptoms again. These patients, between them, had a total of 29 implants done during the study interval with an average interval between implants of 6.4 months.

Patients responding to the survey had a past history of other previous types of treatments. Of those patients answering the survey, 42% had been treated with testosterone ointment, 8% had had testosterone as a tablet or injection, 25% had been previously treated with female hormones, 17% with antibiotics or antifungals, 25% with specific dermatologic preparations such as corticosteroids, and 42% with other or unidentifiable topical treatment.

Patients were asked for their comments about what they liked about the implant therapy. Comments included being impressed with the degree of relief obtained, the fact that many patients did not require any additional therapy between implants, and that the implants were "convenient" as opposed to "messy" topical preparations. No patients reported any side effects attributable to the use of the implants.

In summary, subcutaneously implanted testosterone pellets represent an alternative to therapy of lichen sclerosus with other methods. Many patients experience substantial relief and patients tend to prefer the method because it avoids the inconvenience and messiness of multiple daily applications of topical preparation. It's been my experience that, in patients who are very symptomatic and show significant inflammation, it's necessary to also administer topical corticosteroids at first to help relieve inflammation in order to obtain a response. Also, patients who have been habitually treating themselves with multiple topical preparations may have caused as much irritation by their overtreatment as the disease itself causes and these patients are more difficult to relieve of symptoms.

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The Author

Dr. Wright is in private practice in Springfield, Missouri with the Smith-Glynn-Callaway Clinic. He also serves on the Obstetrics/Gynecology staffs of the Lester E. Cox Medical Center and the St. John's Regional Health Center.

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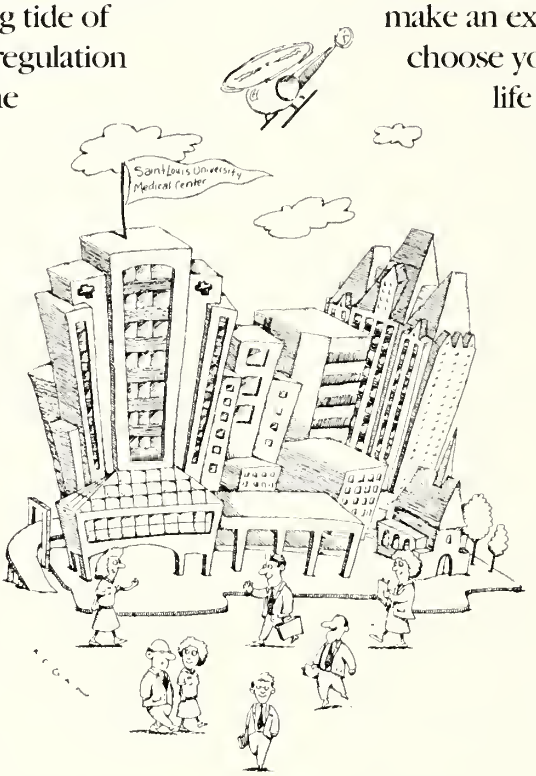
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For Your Benefit

Clinton's plan has AMA elements, yet medicine cannot endorse it

The AMA neither endorsed nor opposed President Clinton's entire health system reform plan, saying it will continue to maintain dialogue with the administration, congressional leaders, and Republican and Democrat sponsors for other proposals to ensure nonpartisan discussions result in final legislation "that puts our patients first."

"We disagree with certain of the president's strategies to achieve commonly shared goals, and we will neither endorse nor oppose the president's preliminary plan in its entirety," the AMA said.

Although it welcomed Clinton's affirmation of many AMA reform principles, the Association warned that the plan's reliance on price controls and overregulation, and its new layers of governmental bureaucracy will limit patient and physician choices, lessen the quality of medical services and undermine the mutual trust between patient and physician.

"While the president proposes rigid spending limits that would also limit resources for patient care, the plan does not consider adequately other major cost-saving areas like liability and antitrust reform," the AMA said.

Financing and implementation issues continue to cause concern as Clinton did not clearly address how he plans to finance reform and that his timetable to enact the plan may be "too aggressive."

The Association cautioned that "heavy reliance on cuts in Medicare and Medicaid for financing is an unrealistic, short-term solution that could threaten medical services for the poor and elderly in the future."

AMA stated Clinton may be creating expectations that cannot be met.

"If anticipated savings fail to materialize from his reform plan, deep reductions in medical services may follow, as many leading economists warn, thus defeating reform's primary purpose," the AMA said.

Actual legislative specifications of Clinton's plan are expected in October. Clinton's speech "is just the beginning of the most important domestic debate of our lifetime," the AMA said.

Dialogue between the administration and AMA will continue during the next stages of the reform process.

The Association also is meeting with congressional leaders and sponsors of Republican and Democratic system reform plans.

Prepared by the AMA Department of Communications Services. For information, call 800 AMA-3211, ext. 4416.

Clinton answers AMA's 10 questions on health system reform

President Clinton answered the AMA's 10 questions on health system reform and included his responses in the White House press kit handed out prior to his congressional speech.

The 10 questions, a handout prepared by the AMA entitled "Is the Clinton proposal for health reform good for you and your family?" originally was designed for physicians to hand out to patients and post in reception areas to encourage open discussion between them.

AMA responses to the 10 questions are included in the all-physician mailing.

AMA directs concerns to Congress; sends analysis of Clinton proposal

The AMA told Congress that organized medicine remains "extremely concerned that any approach not rely too heavily on new and complicated levels of government regulations and restrictive cost containment."

AMA directed this message to every U.S. congressional member in a letter outlining medicine's concerns with the president's health system reform plan.

"We cannot and will not endorse any proposal that could shortchange our patients," the AMA said. This AMA message is timely as Congress begins to analyze and debate the Clinton administration's plan and other system reform proposals.

"Health system reform should not install new structures or limitations that could artificially limit patient choice, do too little to ensure high-quality medicine or rob patients of the security of established patient-physician relationships," said AMA EVP James S. Todd, MD.

An analysis was sent with the letter, highlighting areas of AMA agreement and disagreement with the Clinton plan. It cited "substantial differences with certain approaches in the president's plan."

RUC recommends case management, prolonged service updates

The AMA's Relative Value Scale Update Committee, RUC, provided HCFA with final recommendations for 243 CPT codes that currently have no assigned value in the Proposed Rule as published in the July 14 *Federal Register.*

New code recommendations for case management and prolonged physician services address two important developments in today's primary care medical practice that will improve the quality of care while reducing its costs.

"Care Plan Oversight" codes will fill a major gap in the coding system by allowing physicians to report case management of homebound or nursing home patients who, because of disability, frailty or distance, cannot get to the office. They also are used for the patient whose condition frequently changes and requires substantial care oversight.

"Prolonged Physician Services" codes will provide incentives for physicians to provide care in the most appropriate setting, reducing frequency of expensive emergency department visits and hospital admissions.

HCFA also intends to provide national relative values for additional non-Medicare covered services, such as pediatrics and preventive medicine.

Call for Papers

1994 International Conference on Physician Health
September 16-20, 1994. Ottawa, Ontario, Canada

"Stress: The Profession, the Family and You"

The 1994 International Conference on Physician Health, co-sponsored by the American Medical Association, the Federation of State Medical Boards, the Canadian Medical Association, and the Federation of Medical Licensing Authorities of Canada is scheduled for September 16-20, 1994, at the Ottawa Westin Hotel.

Ottawa is Canada's capital and offers many national museums, over 60 miles of bicycle paths, hiking in Gateneau park, squash courts and swimming at the hotel and golf nearby.

The conference will provide a forum for practitioners and researchers to present recent findings and innovative treatment and education programs in physician health. This conference will address a range of issues, such as AIDS, HIV, problems related to aging, mental illness, substance abuse and physical disabilities and limitations, including those caused by general medical conditions. Possible topics for presentation include: presentation and treatment of health problems among physicians, the impact of disorders on physicians' families and practices, medical-legal issues facing hospital administrations and licensing boards, and material on health promotion and disease prevention. *Abstracts which address issues related to these topics (i.e., prevention, diagnosis, treatment, rehabilitation), but not dealing specifically with physicians are also welcome.*

Three types of presentations regarding these physician health issues are invited:

- **Poster Presentations**
  Written presentations of data-based research, epidemiological research, or program descriptions.

- **Paper Sessions**
  Oral presentation of scientific, data-based findings relative to the topic of physician health.

  Abstracts for poster presentations and paper sessions should contain an introductory statement on the significance of subject matter. Description of methods, results, and conclusions should follow the introductory statement.

- **Workshops**
  Training or instructional presentations, designed to improve specific skills of persons who work in the area of physician health.

  Abstracts for workshops should contain information on the program's intended audience, goals, teaching strategies, and materials. Evaluation data should be summarized

Abstracts may not exceed 200 words. Any abstracts exceeding that length will be rejected. Abstracts should be typed, double spaced, and mailed (not faxed). Four copies of the abstract should be sent, along with one self-addressed, stamped envelope. All submissions must list the primary and secondary authors and their professional affiliations. Telephone number and address of primary author must also be included.

Submissions *must* be received by February 1, 1994.

Abstracts will be submitted for blind review. Abstracts will be judged on their applicability to the conference topic area and their scientific merit. The decisions of the blind reviewers will be communicated to the abstract's primary author by April 1, 1994.

All presenters are expected to register for the conference at the AMA member rate. We are unable to provide any financial support for presenters. Presenters will also be responsible for their own transportation and hotel expenses, as well as making all reservations for same.

Send all materials to:
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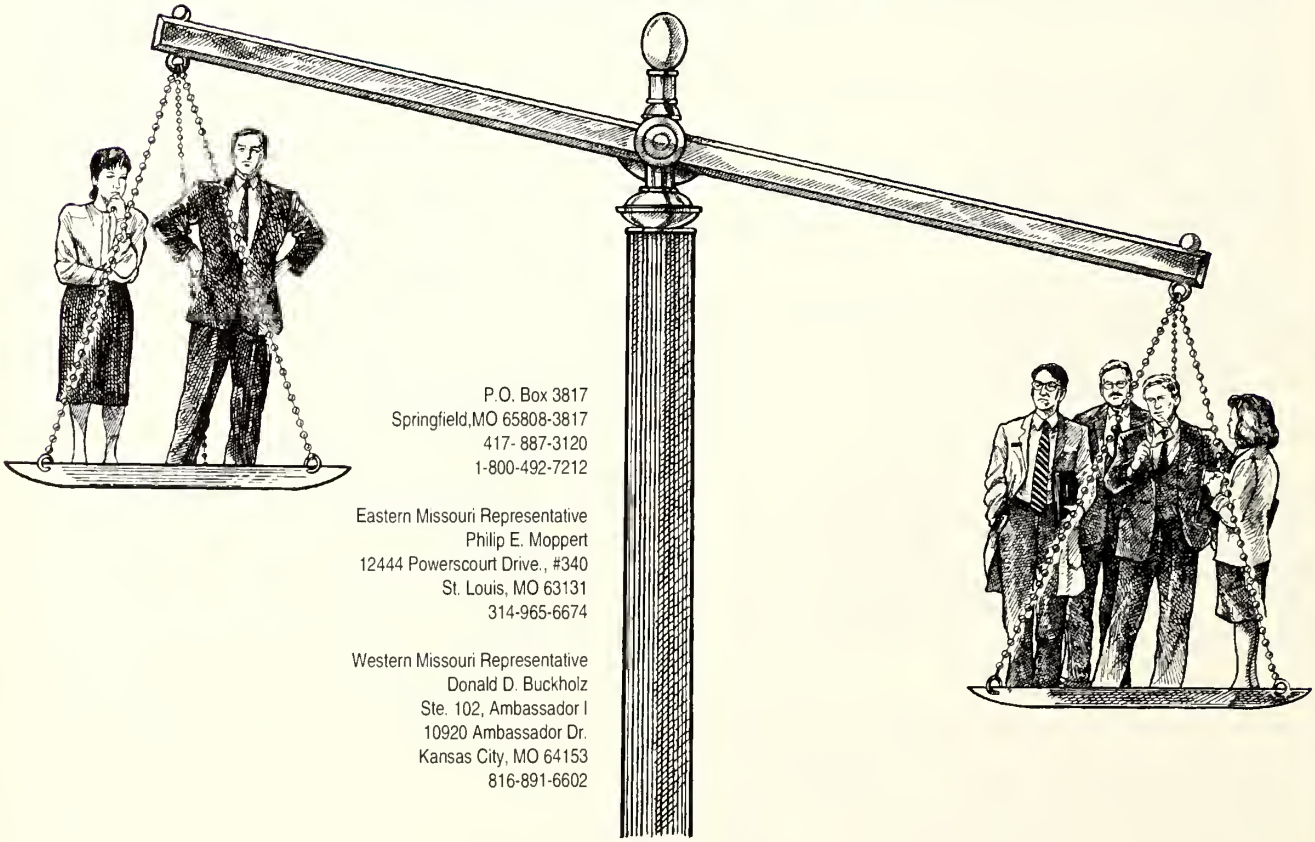

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Tuition Trends for Four Missouri Schools

Craig Carmichael, MSMA-Medical Student Section Chairman

After adjusting for inflation via the Consumer Price Index, today's medical students pay nearly three times as much in tuition and fees as medical students paid twenty years ago. In Missouri, the four schools offering medical degrees have increased at about the same rate as the rest of the nation with an average annual increase of 5% above inflation (Fig. 1).

Annual percentage increases above inflation for Missouri's four medical schools are listed in Table 1. Please understand that these are approximations and are only intended for purposes of comparison. For schools with tuitions which differ for residents and non-residents, tuition calculations are weighted according to the number of in-state and out-of-state students, to reflect the average amount paid by each student. Calculations involving the national average for tuition reflect a similar weighting, since the national average tuition was found by dividing the total amount of tuition and fees collected by all medical schools by the total number of American medical students.

As is evident from Table 1, these Missouri schools should be commended for controlling their tuition charges over the past twenty years and for offering students some real bargains. The University of Missouri-Columbia is the obvious example, offering state residents an education at half the price of most other medical schools. Washington University is commendable as well, pricing itself very close to the national average, even though it could charge much more based on student demand to attend (very large number of applicants).

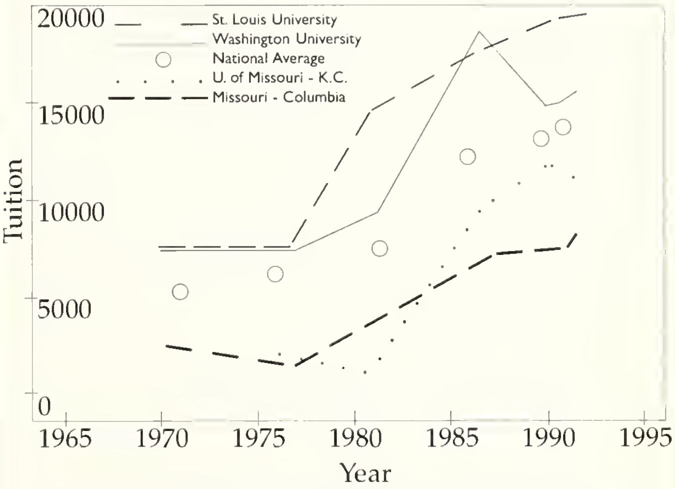

Figure 1 - Trends in Tuition for Four Missouri Medical Schools in Constant 1991 Dollars

TABLE I.

Inflation Adjusted Annual Percentage Increases In Tuition (Approximate) for Four Missouri Medical Schools Between 1970 and 1992, and Tuition and Fees assessed in 1992-1993.

School	Annual Increase 1970-1981	1981-1992	Tuition 1992-1993
Washington University	1.7%	4.3%	$19,800[1]
St. Louis University	4.7	3.2	21,260
Missouri Columbia	4.5	6.1	9,289[2] 15,528[3]
Missouri Kansas City	NA	12.6	9,549[2] 18,226[3]
National Average	4.2	5.2	

[1] Washington University Tuition is Frozen (Constant for the Class of 1996 for all four medical school years).
[2] Missouri Residents
[3] Non-Missouri Residents

Some schools may be changing their policy, however. The University of Missouri is in the middle of a five-year plan to increase tuition by 79%, and some medical school deans fear that this will make Missouri one of the most expensive state medical schools in the country. Washington University also has proposed significant tuition increases for the next few years, although these are difficult to interpret since tuition was recently frozen for each entering class.

Tuition containment is the most just way to ensure equal access to students of all socioeconomic backgrounds and to provide the freedom for students to enter primary care and work in underserved areas. For this reason, these Missouri medical schools should be praised for their tuition-containment efforts of the past, and encouraged to continue these efforts long into the future.

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University of Missouri-Columbia

The University of Missouri is one of 28 medical school centers receiving a grant for the next three years from the Health of the Public Program. The grant will be used to emphasize the care of rural patients. A Rural Health Initiative Committee was recently formed. The Pew Charitable Trusts and The Robert Wood Johnson Foundation (in collaboration with the Rockefeller Foundation) sponsor the program.

Jack Colwill, MD, professor and chairman of the department of family and community medicine, is the principal investigator for the grant. **Steven C. Zweig, MD,** associate professor, in the department of family and community medicine and **Jane Armer, PhD,** assistant professor, in the School of Nursing are co-principal investigators. **Gordon Brown, PhD,** director of the health services management program will also participate.

Projects funded by the grant include:

- A pilot project in which a small group of medical students and graduate students in nursing and health services management will work together at a rural practice.
- Development of two new rural teaching practices in mid-Missouri communities.
- The Schools of Nursing and Medicine will work together to train nurse practitioner students, medical students and resident physicians in collaborative practice models at one or both of existing rural clinics.
- Establishment of a Health of the Public Scholars program that will enroll one fourth-year medical student each year to work on a master's degree in public health, studying rural health care and health policy.
- Faculty conducting more research studies and demonstration projects designed to learn about and improve the health care of rural Missourians. An earlier Health of the Public grant provided for a study of the care nursing home residents receive and the physicians who provide much of that care.

A team of MU and Veterans Administration researchers has received a five-year grant to further the work of the Missouri Arthritis Rehabilitation Research and Training Center (MARRTC). The grant from the U.S. Department of Education will fund seven major projects focusing on improving life for people with arthritis and related musculoskeletal diseases.

Gordon Sharp, MD, director of immunology and rheumatology, is co-director of MARRTC along with **Jerry C. Parker, PhD,** clinical associate professor of internal medicine and chief of the psychology service at the Harry S. Truman Veteran's Hospital and **Henry Stonnington, MD,** professor and chairman of the department of physical medicine and rehabilitation and medical director of Rusk Rehabilitation Center.

MARRTC projects will include: producing individualized exercise programs on videotape for people with osteoarthritis; making conditioning exercise programs available to mid-Missourians with arthritis; managing depression to reduce disability in rheumatoid arthritis patients; interventions to prevent disability in children with juvenile rheumatoid arthritis; using medications and exercise to reduce disability in fibromyalgia patients; establishing an interdisciplinary Arthritis Rehabilitation and Community Integration Clinic in Columbia as a model for providing comprehensive rehabilitation services to persons with arthritis; and collaborating with the School of Journalism to better educate the public about arthritis.

Dr. Gordon Sharp has been awarded a Curators' Professorship for 1993. He is one of only 13 MU professors to receive this award. First presented in 1970, it is one of MU's highest distinctions. Dr. Sharp, as previously mentioned, is associate chairman of the department of internal medicine and director of the division of immunology and rheumatology and the MARRTC. He joined MU faculty in 1969 and earned an international reputation in 1972 with his original identification of mixed connective tissue disease, also known as Sharp's syndrome.

St. Louis University

Kathleen S. Wright, EdD, MPH, has been named associate dean of St. Louis University's School of Public Health. Dr. Wright is known for her work in the field of public health and has received several national and state grants. She has been a public health associate with the Missouri Department of Health, an American Scandinavian Foundation Fellow at the University of Copenhagen, and director of the educational resources department at the corporate offices of the SSM Health Care System. Other appointments include, **Barbara Arrington, PhD,** as acting chairwoman of the department of health administration and **R. Gregory Evans, PhD,** as acting chairman of the department of community health.

George T. Grossberg, MD, professor of psychiatry and human behavior and director of the division of geriatric psychiatry is leading research to investigate whether people suffering from Alzheimer's disease benefit from a drug called physostigmine. Physostigmine is known to improve attention and recall. It was one of the first medications tried with Alzheimer's patients 10 years ago. Considered effective, it did have drawbacks such as causing stomach problems and lasting only a couple of hours when taken in the wrong dosage intravenously. Many of the side effects have been eliminated as the drug has been developed into a time-release capsule that can be taken twice a day. Volunteers interested in participating in this study must be diagnosed with Alzheimer's disease and in good physical health. For more information, call (314)577-8741.

University of Missouri - Kansas City

Matthew C. Gratton, MD, associate professor in the department of emergency medicine, received the School of Medicine's 1993 Elmer P. Pierson Outstanding Teaching Award. The award was presented at the school's convocation ceremony October 1.

Gary Salzman, MD, associate professor and assistant dean in the department of internal medicine, received the 1993 Alumni Achievement Award during the same ceremony. The award recognizes alumni from each academic unit who have given outstanding service to the community and have earned a local or regional reputation.

Fong Y. Tsai, MD, professor and chairman of the department of radiology, has been invited to be a guest lecturer at the Ninth Annual Meeting of the Japanese Society of Intravascular Neurosurgery in Sendai, Japan, in November. His lecture will be on Thrombolysis for Stroke Victims.

Washington University

The brain's motor cortex may not contain as well-ordered a map of the body as previously thought. **Marc H. Schieber, MD, PhD,** assistant professor of neurology and neurosurgery, is lead author of a paper that proposes a more flexible hypothesis. Instead of delegating control of one particular finger to specific strip of neurons, researchers found that the brain orchestrates finger movement by allowing neurons from all over the motor cortex hand area to help move each finger. The evidence refutes the long-standing belief that each finger is operated by a discrete set of neurons. The findings could mean that people with a brain injury that affects part of the hand area may be able to train remaining areas of the motor cortex to take over the tasks formerly handled by the damaged area.

Researchers have developed a test that measures the percentage of ingested cholesterol that reaches the bloodstream from the intestine.

Past studies of intestinal absorption were limited. The only available method used radioactive materials so the studies often excluded women and children.

This new test used two synthetic, nonradioactive forms of cholesterol, one labeled with a rare form of carbon, the other labeled with a rare form of hydrogen. Sixteen volunteers, seven women and nine men, 21 through 63, received one type of cholesterol as part of a meal and received the other type in an injection. After three days, the investigators took blood samples and measured the labeled cholesterol with gas chromatography-mass spectrometry. From the collected values, the percentage of ingested cholesterol that reached the bloodstream was calculated. Absorption ranged from 37 to 70 percent. The test will be used for continuing research to find out what makes someone a high absorber, if changes in diet will affect a person's absorption rate, and to discover the genetics of cholesterol absorption. **Matthew A. Bosner, MD,** assistant professor of medicine is lead author of the study, and **Richard E. Ostlund Jr., MD,** associate professor of medicine is co-author.

A new mental health program specifically for women has opened at Washington University. The Women's Mental Health Network will offer multi-disciplinary approach to help women with psychological and psychiatric problems. The staff includes psychiatrists, psychologists and social workers who specialize in mental health issues that are specific to women. Such disorders include post-partum depression, premenstrual syndrome, menopause and emotional problems that result from physical illnesses like breast and ovarian cancers. The network provides special services to women on both an inpatient and outpatient basis.

Volunteers are needed for a study to determine the effectiveness of psychotherapy for patients with diabetes who also suffer clinical depression. The study is for patients with both depression and Type II, or adult onset diabetes. **Patrick J. Lustman, PhD,** associate professor of medical psychology and psychiatry, concluded from a first study that anti-depressant drugs are effective in some patients with diabetes. From this next study, he wants to learn whether cognitive therapy can also be effective. For information, call Linda Griffith, study coordinator, at 314/362-2415.

MEMBERSHIP NEWS

Joseph R. Simpson, MD, of St. Louis, has been named as a fellow of the American College of Radiology (ACR). He was selected for his outstanding contributions to the field of radiology. The College's Board of Chancellors selected 112 new fellows based on member's significant or clinical research in the field of radiology or significant contributions to its literature. Other criteria for selection include performance of outstanding service as a teacher of radiology, service to organized medicine and an outstanding reputation among colleagues and the local community as a result of long-term superior service. The announcement was made during the ACR annual meeting, in September, at Orlando, Florida.

NEW MEMBERS

❖ **William T. Betz, DO,** 12121 Blue Ridge Blvd., Suite M, Grandview, MO 64030, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Betz received his doctor of osteopathy at the University of Health Sciences College of Osteopathic Medicine, Kansas City in 1981. He completed his residency at Lakeside Hospital, Kansas City. Dr. Betz specializes in family practice.

❖ **Richard W. Burns, MD,** 1505 Southwest Blvd., Jefferson City, MO 65109, has become a member of the Cole County Medical Society. Dr. Burns received his medical degree at the University of Missouri-Columbia in 1990. He completed his residency at the University of Missouri-Columbia. Dr. Burns specializes in internal medicine.

❖ **Sara A. Bohn, DO,** R#3 Hwy 87 S., Box 99, California, MO 65108, has become a member of Cole County Medical Society. Dr. Bohn received her doctor of osteopathy at the University of Health Sciences Osteopathic in 1989. She completed an internship at Trinity Lutheran Hospital. Dr. Bohn specializes in family practice.

❖ **Robert J. Boulware, MD,** 103 11th Street, Suite #14, Chillicothe, MO 64601, has become a member of the Grand River Medical Society. Dr. Boulware received his medical degree at the University of Missouri-Kansas City in 1990. He completed his residency at Jewish Hospital at Washington University. Dr. Boulware specializes in internal medicine.

❖ **Patrick L. Bruno, MD,** 711 Grand Ave., Hannibal, MO 63401, has become a member of the Northeast Missouri Medical Society. Dr. Bruno received his medical degree at the University of Missouri-Columbia in 1989. He completed his residency at the University of Missouri-Columbia Hospital & Clinics. Dr. Bruno specializes in obstetrics and gynecology.

❖ **Mark P. Bryer, MD,** 3600 W. Vaughter Rd., Columbia, MO 65201, has become a member of the Boone County Medical Society. Dr. Bryer received his medical degree at the University of Pennsylvania in 1986. He completed his residency at the University of Pennsylvania. Dr. Bryer specializes in radiation oncology.

❖ **John J. Corzine, DO,** 5325 Faraon, St. Joseph, MO 64506, has become a member of the Buchanan County Medical Society. Dr. Corzine received his doctor of osteopathy at Kansas City College of Osteopathic Medicine in 1979. He completed his residency at the University of Health Sciences, Kansas City. Dr. Corzine specializes in anesthesiology.

❖ **John W. Cowden, MD,** 1 Hospital Drive, Columbia, MO 65212, has become a member of the Boone County Medical Society. Dr. Cowden received his medical degree at the University of Michigan in 1964. He completed his residency at Walter Reed General Hospital, Washington, DC. Dr. Cowden specializes in ophthalmology.

❖ **Michael M. Daly, DO,** 201 W. Broadway, Columbia, MO 65203, has become a member of the Boone County Medical Society. Dr. Daly received his doctor of osteopathy at Kirksville College of Osteopathic Medicine in 1971. He completed his residency at Charles Still Hospital, Jefferson City. Dr. Daly specializes in family and internal medicine.

❖ **Thomas M. Dougherty, Jr., MD,** 400 W. Clay Ave., Plattsburg, MO 64477, has become a member of the Clinton County Medical Society. Dr. Dougherty received his medical degree at Kansas University in 1986. He completed his residency at the Medical College of Wisconsin, Milwaukee. Dr. Dougherty specializes in family practice.

❖ **Steven Gnatz, MD,** 501 Rusk Rehabilitation, 1 Hospital Drive, Columbia, MO 65212, has become a member of the Boone County Medical Society. Dr. Gnatz received his medical degree at the University of Illinois in 1984. He completed his residency at Baylor College of Medicine Affiliated Hospitals, Houston. Dr. Gnatz specializes in physiatry.

❖ **William M. Grant, MD,** N613 HSC, 1 Hospital Drive, Columbia, MO 65212, has become a member of the Boone County Medical Society. Dr. Grant received his medical degree at the University of Missouri-Columbia in 1986. He completed his residency at the University of Texas, San Antonio. Dr. Grant specializes in obstetrics and gynecology.

❖ **Brenda A. Hettinger, MD,** 103 E. 11th St., Suite 2, Chillicothe, MO 64601, has become a member of the Grand River Medical Society. Dr. Hettinger received her medical degree at the University of Missouri-Columbia in 1991. She completed an internship at the University of Missouri-Columbia. Dr. Hettinger specializes in general practice.

❖ **Melvin D. Karges, MD,** 6650 Troost, Suite 100, Kansas City, MO 64131, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Karges received his medical degree at the University of Kansas in 1981. He completed his residency at the University of Kansas Medical Center. Dr. Karges specializes in physical medicine and rehabilitation.

❖ **James J. Kinderknecht, MD,** 400 Keene St., Columbia, MO, has become a member of the Boone County Medical Society. Dr. Kinderknecht received his medical degree at the University of Kansas in 1986. He completed his residency at the Good Samaritan Medical Center, Phoenix, Arizona. Dr. Kinderknecht specializes in family practice and sports medicine.

❖ **John P. Koonce, MD,** 1025 Northeast Drive, Jefferson City, MO 65109, has become a member of the Cole County Medical Society. Dr. Koonce received his medical degree at the University of Missouri-Columbia in 1978. He completed his residency at Dartmouth-Hitchcock Medical Center, Hanover, New Hampshire. Dr. Koonce specializes in urology.

❖ **J. Eric Loma, MD,** 427 Cahill Rd., Suite 202, Branson, MO 65616, has become a member of the Tri-Lakes Medical Society. Dr. Loma received his medical degree at Baylor College of Medicine, Houston in 1980. He completed his residency at Baylor Affiliated Hospitals. Dr. Loma specializes in plastic surgery.

❖ **Don R. Snodgrass, MD,** 621 S. New Ballas Rd., Creve Coeur, 63141, has become a member of the Missouri State Medical Association. Dr. Snodgrass received his medical degree at the University of Texas Southwestern, Dallas in 1984. He completed his residency at St. John's Mercy Medical Center, Creve Coeur. Dr. Snodgrass specializes in internal medicine.

❖ **Gary Spitzer, MD,** 3635 Vista Ave. at Grand Blvd., St. Louis, MO 63110, has become a member of the Missouri State Medical Association. Dr. Spitzer received his medical degree at the Royal Australian College of Physicians in 1971. He completed his residency at the Royal Melbourne Hospital. Dr. Spitzer specializes in oncology.

❖ **Scott A. Wade, MD,** 1314 N. 36th St., St. Joseph, MO 64506, has become a member of the Buchanan County Medical Society. Dr. Wade received his medical degree at the University of Missouri-Columbia in 1987. He completed his residency at the University of Kansas Medical Center. Dr. Wade specializes in general surgery.

❖ **Daniel G. Wagner, MD,** 224 S. Woods Mill Rd., Suite 750 S., Chesterfield, MO 63017, has become a member of the Missouri State Medical Association. Dr. Wagner received his medical degree at St. Louis University in 1989. He completed his residency at Indiana University Medical Center. Dr. Wagner specializes in obstetrics and gynecology.

❖ **Michael J. Wempe, MD,** 5325 Faraon Street, St. Joseph, MO, 64500, has become a member of the Buchanan County Medical Society. Dr. Wempe received his medical degree at the University of Nebraska in 1982. He completed his residency at the University of Nebraska. Dr. Wempe specializes in anesthesiology.

❖ **Carroll R. Wetzel, MD,** 603 Gaines Dr., Clinton, MO 64735, has become a member of the Henry County Medical Society. Dr. Wetzel received his medical degree at Tulane Medical School, New Orleans in 1987. He completed his residency at Achsner Foundation Medical School, New Orleans. Dr. Wetzel specializes in general surgery.

RESIDENTS

George M. Kichura, MD - *Internal Medicine*
Julia J. Lunberry, MD - *Internal Medicine*
Sean T. McLaughlin, MD - *Internal Medicine*
Steven J. Stokesbary, MD - *Orthopedics*

STUDENTS

University of Missouri- Kansas City

Vivian Lee
Laurie A. Ohnesorge
James K. Turnbo

St. Louis University

Mark K. Fromke
Nathan P. Peimann
Phillip D. Reichert

Washington University

Alison M. Barnes
Dana A. Kumar
Francoise G. Le

IN MEMORIAM

■ **Eugene C. Beatty, Jr., MD,** Overland Park, Kansas, died August 13, 1993, at age 71. Dr. Beatty received his medical degree at the University of Colorado in 1946. He was a pathologist at Children's Mercy Hospital for 25 years. From 1954 to 1968 he was on staff at Denver Children's Hospital. He was a flight surgeon at Lowry Air Force Base, Colorado, and served in the Army Air Forces for two years. Dr. Beatty was a member of the Metropolitan Medical Society of Greater Kansas City, the Missouri State and American Medical Associations, the American Board of Pathologists, the American Society of Clinical Pathology, and the College of American Pathologists.

■ **Francis G. Duffy, MD,** Clayton, Missouri, died September 7, 1993, at age 68. Dr. Duffy received his medical degree at University College, Dublin Medical School, Ireland, in 1951. After he came to the United States in 1957, he was appointed chief of anesthesiology at the Homer G. Phillips Hospital. In 1963, he joined St. Luke's Hospital and practiced there until retirement in 1991. He was chief of the anesthesiology department at St. Luke's from 1968 to 1980. Dr. Duffy was a member of the International Anesthesia Research Society and the American Society of Anesthesiologists.

■ **Carl R. Ferris, MD,** Kansas City, Missouri, died September 26, 1993, at age 96. Dr. Ferris received his medical degree at the Kansas University in 1924. He practiced for 57 years before retiring in 1983. Dr. Ferris was past president of the medical staff of Research Hospital. In 1984, the hospital's library was named after him. He was past president of the Kansas City Southwest Clinical Society, the Jackson County Medical Society and the Greater Kansas City Society of Internists. Dr. Ferris was a member of the American College of Physicians, the American Society of Internal Medicine and the Fifty Year Club of American Medicine.

■ **Stanley B. Lyss, MD,** Clayton, Missouri, died September 17, 1993, at age 57. Dr. Lyss received his medical degree at Washington University in 1962. He was a pediatrician in private practice and on the staff at St. Louis Children's Hospital for the last 26 years. Dr. Lyss was president of the medical staff from 1981 to 1983. He was also on the staffs at Barnes and Jewish hospitals and St. John's Mercy Medical Center. He was an assistant professor of clinical pediatrics at Washington University. Dr. Lyss was a member of the American Academy of Pediatrics and the American Physicians Fellowship, Inc.

■ **Joseph M. Masucci, MD,** Kansas City, Missouri, died June 24, 1993, at age 63. Dr. Masucci received his medical degree at Marquette University in 1965. He was a staff physician for Trinity Lutheran Hospital and formerly was on the staff of St. Mary's Hospital. He was formerly a company physician for the Southern Pacific and Union Pacific railroads. Dr. Masucci was a member of the Metropolitan Medical Society of Greater Kansas City, the Missouri State and American Medical Associations and the American Academy of Family Physicians.

■ **Theodore L. Paletta, MD,** Creve Coeur, Missouri, died September 18, 1993, at age 56. Dr. Paletta received his medical degree at the University of Cincinnati Medical School in 1964. While serving as chief of medicine and cardiology at an Army hospital in Vietnam, Dr. Paletta was the first physician there to implant a pacemaker and to organize a cardiac intensive care unit. He was honored by the Vietnamese government for his effort. Dr. Paletta was in private practice in St. Louis since the early 1970s. Dr. Paletta was on staff at Missouri Baptist Hospital, St. Louis University Hospital, St. Joseph's Hospital of Kirkwood, St. Mary's Health Center and DePaul Health Center. He was a clinical instructor of cardiology at St. Louis University. Dr. Paletta was past vice president and councilor of both the Missouri State Medical Association and the St. Louis Metropolitan Medical Society. He was a member of the American College of Physicians, the American College of Cardiology, and the American Geriatrics Society, Inc.

■ **Nicholas S. Pickard, MD,** Mission Hills, Kansas, died September 16, 1993, at age 82. Dr. Pickard received his medical degree at the University of Pennsylvania in 1935. He began practice as an orthopedic surgeon with the Dickson-Diveley Clinic. Dr. Pickard was in private practice from 1944 until retirement in 1968. He was a member of the Clinical Orthopedic Society.

■ **Henry W. Walters, MD,** Clayton, Missouri, died September 19, 1993, at age 85. Dr. Walters received his medical degree at the University of Nebraska in 1934. He practiced in Minnesota and New York before moving to St. Louis. Dr. Walters was a dermatologist in Clayton for 34 years. During WWII, he served as a colonel in the Army Medical Corps. He was a member of the American College of Chest Physicians and the American Thoracic Society.

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CME CALENDAR

The continuing medical education accreditation program of the MSMA has full approval by the AMA's Council on Medical Education. The institutions and functions listed here qualify for Category I credit for the AMA Physician Recognition Award. All accredited institutions in Missouri are invited to send CME information for listing in *MISSOURI MEDICINE*. Please remember to include the name of the individual who can be contacted at your institution for additional information about your CME events.

November

3 - *St. Louis*: Updates in Psychiatry/Psychotherapy. 3.5 credit hours. Contact St. John's Mercy Medical Center, 314/569-6290.

4 - *St. Louis*: 1993 Pediatric Trauma: Little Patients, Big Trauma. 6.5 credit hours. Contact Diana Fendya, RN, MSN, St. Louis University, 314/577-5312.

4 to 6 - *Kansas City*: Kansas City Southwest Clinical Society's 71st Annual Fall Clinical Conference. Contact Linda F. Smutz, 816/523-3383.

5 & 6 - *St. Louis*: Allergy for the Clinician: Practical Solutions to Everyday Problems. 9.5 credit hours. Contact St. Louis University School of Medicine, CME office, 314/577-8167 or 800/553-2712.

5 to 7 - *St. Louis*: Microsurgery of the Temporomandibular Joints. 20 credit hours. Contact St. Louis University, CME, 577-8167 or 800/2712.

6 - *St. Louis*: Corneal Topography Skills Transfer. 7 credit hours. Contact Kerry Assil, MD, 314/865-8333.

8 to 10 - *St. Louis*: Practical Anatomy and Surgical Technique Workshop - Approaches to Cranio-Cervical Fixation. Contact St. Louis University School of Medicine, CME office, 314/577-8167 or 800/553-2712.

8 - *St. Louis*: City-Wide Radiology Conference: John V. Crues, MD - MRI of the Shoulder. Contact R. Gilbert Jost, MD, Chief of Diagnostic Radiology, Mallinckrodt Institute of Radiology, 314/362-7130.

10 to 12 - *St. Louis*: Pediatric Advanced Cardiac and Trauma Support for Life/Pediatric Advanced Life Support Provider Course. 20 credit hours. Contact Mary Beth Foerstel, St. Louis University, CME Office, 314/577-5385.

11 to 14 - *St. Louis*: Anesthesiology & The Geriatric Patient. Contact CME, Washington University 314/362-6893 in MO or 800/325-9862 interstate.

12 & 13 - *St. Louis*: Practical Anatomy and Surgical Technique Workshop: Advanced Applications in Endoscopic Neurosurgery. 14 credit hours. Contact St. Louis University School of Medicine, CME office, 314/577-8167 or 800/553-2712.

12 & 13 - *Washington, DC*: Interdisciplinary Approach to the Diagnosis and Management of Endocrine Disorders. 13.5 credit hours. Contact Daniel E. Reichard, George Washington University, CME, 202/994-4285.

12 & 13 - *St. Louis*: Innovations in Oral Cavity Cancer. Contact CME, Washington University 314/362-6893 in MO or 800/325-9862 interstate.

12 to 14 - *Big Cedar Lodge, Branson*: MAFP Fall CME Conference. 10 hours of CME offered. Over 20 possible CME hours offered. Contact MAFP, 8301 State Line Rd., Suite 102, Kansas City, MO 64114, 816/747-5114.

12 to 14 - *St. Louis*: 20th Annual Anesthesia and the Geriatric Patient. 16.25 credit hours. Contact CME, Washington University 314/362-6893 in MO or 800/325-9862 interstate.

13 - *Kansas City*: 5th Annual Conference on Osteoporosis. 5 credit hours. Contact the Metropolitan Medical Society of Greater Kansas City, 816/531-8432.

13 - *St. Louis*: Infectious Disease Challenges for the Primary Care Physician. 3 credit hours. Contact St. Louis University, CME, 314/577-8167 or 800/553-2712.

13 - *Columbia*: 7th Annual Obstetrics & Gynecology Update. Contact Barry Kling, University of Missouri, 314/882-4105.

16 & 17 - *St. Louis*: Advances in the Management of HIV Disease. 8.5 credit hours. Contact Susan Wightman, R.N., Washington University, 314/362-2418 or 800/432-0448.

16 to 18 - *St. Louis*: Doppler Echocardiography Course. 20 credit hours. Contact Dianne Reid, St. Louis University, 314/577-8897.

17 to 19 - *St. Louis*: Contemporary Cardiothoracic Surgery. 21.5 credit hours. Contact CME, Washington University 314/362-6893 in MO or 800/325-9862 interstate.

19 & 20 - *St. Louis*: 21st Annual Kilo Diabetes Symposium: Current Topics in Diabetes & Vascular Disease. 13 credit hours. Contact Jackie Dudley, R.N., Kilo Diabetes & Vascular Research Foundation, 314/434-6500.

20 - *St. Louis*: Hypercholesterolemia Seminar. Contact CME, Washington University 314/362-6893 in MO or 800/325-9862 interstate.

20 - *Springfield*: Practicing Medicine: Current Topics for 1994. 5.5 credit hours. Contact Jean Hillmer, 417/836-8787.

29 to Dec. 1 - *Springfield*: Advanced Life Support Provider Course. 22.5 credit hours. Call Linda Climer, St. John's Regional Health Center, 417/885-2648.

December

2 - *Springfield*: Advanced Cardiac Life Support Recertification Course. 8 credit hours. Call Linda Climer, St. John's Regional Health Center, 417/885-2648.

2 & 3 - *Kansas City*: The Heart - 1993. Contact Beth M. Paul, St. Luke's Hospital of K.C., 816/932-2301, fax #816/932-5119.

3 - *St. Louis*: Women's Healthcare Issues '93. Contact CME, Washington University 314/362-6893 in MO or 800/325-9862 interstate.

3 - *Kansas City*: Future Directions in the Management of Fungal Infections. 3 credit hours. Contact Dr. David McKinsey, 816/276-3317.

3 to 5 - *St. Louis*: Practical Anatomy and Surgical Technique Workshop - Approaches to Cranio-Cervical Fixation. Contact St. Louis University School of Medicine, CME office, 314/577-8167 or 800/553-2712.

4 - *St. Louis*: GI Update. Contact CME, Washington University, 314/362-6893 in MO or 800/325-9862 interstate.

4 - *St. Louis*: 5th Annual Symposium for Medical Directors in Nursing Homes. 6.75 credit hours. Contact St. Louis University, CME, 314/577-8167 or 800/553-2712.

6 to 8 - *St. Louis*: Practical Anatomy and Surgical Technique Workshop: Temporal Bone Surgical Dissection - Exploring New Surgical Instrumentation with Midas Rex Hands-On

Workshop. 16 credit hours. Contact the St. Louis University, CME Office at 314/577-8167 or 800/553-2712.

10 to 12 - *Springfield*: ACLS Provider Course. 18 credit hours. Call Donna Willoughby, Cox South, 417/885-4117.

10 to 13 - *Chesterfield*: Advances in Internal Medicine. Contact Barry Kling, University of Missouri-Columbia, 314/882-4105.

11 - *St. Louis*: Cardiology Seminar. Contact CME, Washington University, 314/362-6893 in MO or 800/325-9862 interstate.

13 - *St. Louis*: City-Wide Radiology Conference by James A. Brink, MD - Spiral CT: Update 1993. Contact R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology, 314/362-7130, fax #314/361-5428.

27 to 31 - *Snowbird, UT*: Drug Therapy for the 90's: An Update in Mechanisms of Action in Clinical Utilization. 18 credit hours. Contact Daniel E. Reichard, George Washington University, 202/994-4285.

January

10 - *St. Louis*: City-Wide Radiology Conference, St. Louis University. Contact R. Gilbert Jost, MD, Chief of Diagnostic Radiology, Mallinckrodt Institute of Radiology, 510 S. Kingshighway, St. Louis, MO 63110, 314/362-7130.

14 - *Springfield*: Pediatric Advanced Life Support Recertification Course. 7 credit hours. Call 417/885-4117.

18 - *Kansas City*: Perinatal Core Curriculum Workshop #1. 5 credit hours. Contact Carol Osborne, St. Luke's Hospital of K.C., 816/932-3737, fax - 816/932-5119.

24 to 26 - *Orlando, FL*: 14th Annual Conference on Peritoneal Dialysis. Contact Barry Kling, University of Missouri-Columbia, 314/882-4105.

24 to 28 - *St. Louis*: The Medicolegal Death Investigator Training Course. 33 credit hours. Contact Mary Fran Ernst, 314/522-6410, ext. 6509.

February

1 - *Kansas City*: Perinatal Core Curriculum Workshop #2. 5 credit hours. Contact Carol Osborne, St. Luke's Hospital of K.C., 816/932-3737, fax - 816/932-5119.

14 - *St. Louis*: 8th Annual Daniel R. Biello Memorial Lecture: Henry D. Royal, MD - Pulmonary Embolism: Scientific Challenges. Contact R. Gilbert Jost, MD, Chief of Diagnostic Radiology, Mallinckrodt Institute of Radiology, 510 S. Kingshighway, St. Louis, MO 63110, 314/362-7130.

15 - *Kansas City*: Perinatal Core Curriculum Workshop #3. 5 credit hours. Contact Carol Osborne, St. Luke's Hospital of K.C., 816/932-3737, fax - 816/932-5119.

26 to March 5 - *Barbados*: Topics in Gastroenterology and Internal Medicine. 15 credit hours. Contact Maria Gorrick, George Washington University, CME, 202/994-4285.

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EMERGENCY MEDICINE OPPORTUNITIES - Coastal Emergency Services, a leader in emergency department staffing, has opportunities throughout the state in emergency departments of varying volume. Medical Directorships are also available. Remuneration commensurate with volume and acuity. Groups claims made insurance procured on your behalf. Qualifications: BE/BC primary care physicians with a minimum of 1500 hours in emergency department of similar volume. Contact Brian Nunning or Marilyn Morris for further information. 800-326-2782.

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PSYCHIATRIST - The VA Medical Center, Poplar Bluff, Missouri, is seeking a B/C psychiatrist to serve as Chief, Psychiatric Service at this 200-bed medical, surgical, and psychiatric facility. Experience/training in substance abuse, geriatric mental health and/or PTSD would be a strength to any applicant. Good ancillary staff to work with. Physicians in the VA do not need malpractice insurance as they are covered by Federal Torts Act. Good benefits such as 30 days vacation/15 days sick leave per year, low cost health/life insurance and 3-tier retirement plan with 401 (K) option. Poplar Bluff, MO is located in scenic SE Missouri Ozark foothills and per U.S. Chamber of Commerce has one of the lowest cost-of-living in U.S. Interested physicians should contact Chief of Staff, VA Medical Center, Poplar Bluff, MO 63901, or call (314)686-4151 ext. 201. An EOE.

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INFORMATION FOR CONTRIBUTORS

Articles are accepted for publication on condition that they are contributed solely to this journal. Material appearing in *MISSOURI MEDICINE*, is protected by copyright.

Manuscripts should be submitted to the editor, **J. Regan Thomas, MD,** P.O. Box 1028, 113 Madison, Jefferson City, MO 65102. The transmittal letter should designate one author as correspondent and include his or her address and telephone number.

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Manuscripts

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YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:
1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991,14.146-151.

PRAVACHOL® (Pravastatin Sodium Tablets)

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and *lactation.* Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SO 31,906). A small increase was seen in mean AUC values and half-life (t1/2) for the inactive enzymatic ring hydroxylation metabolite (SO 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SO 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SO 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.

Other Drugs. During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0 5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*, a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells, and a gene conversion assay using *Saccharomyces cerevisiae* In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter^2). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated, adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy. this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1 9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1 4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1 2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting

Reproductive. gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required

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Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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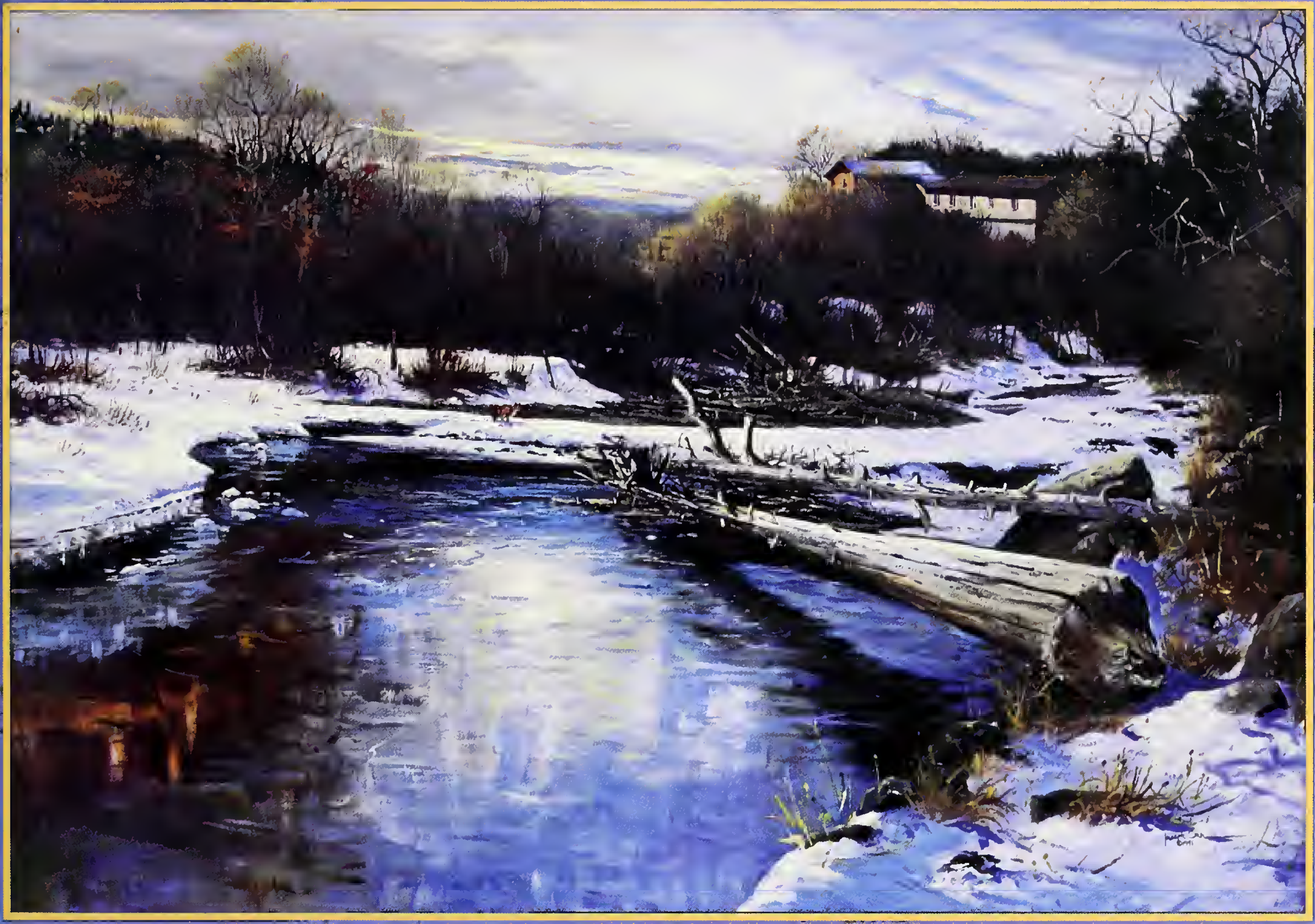

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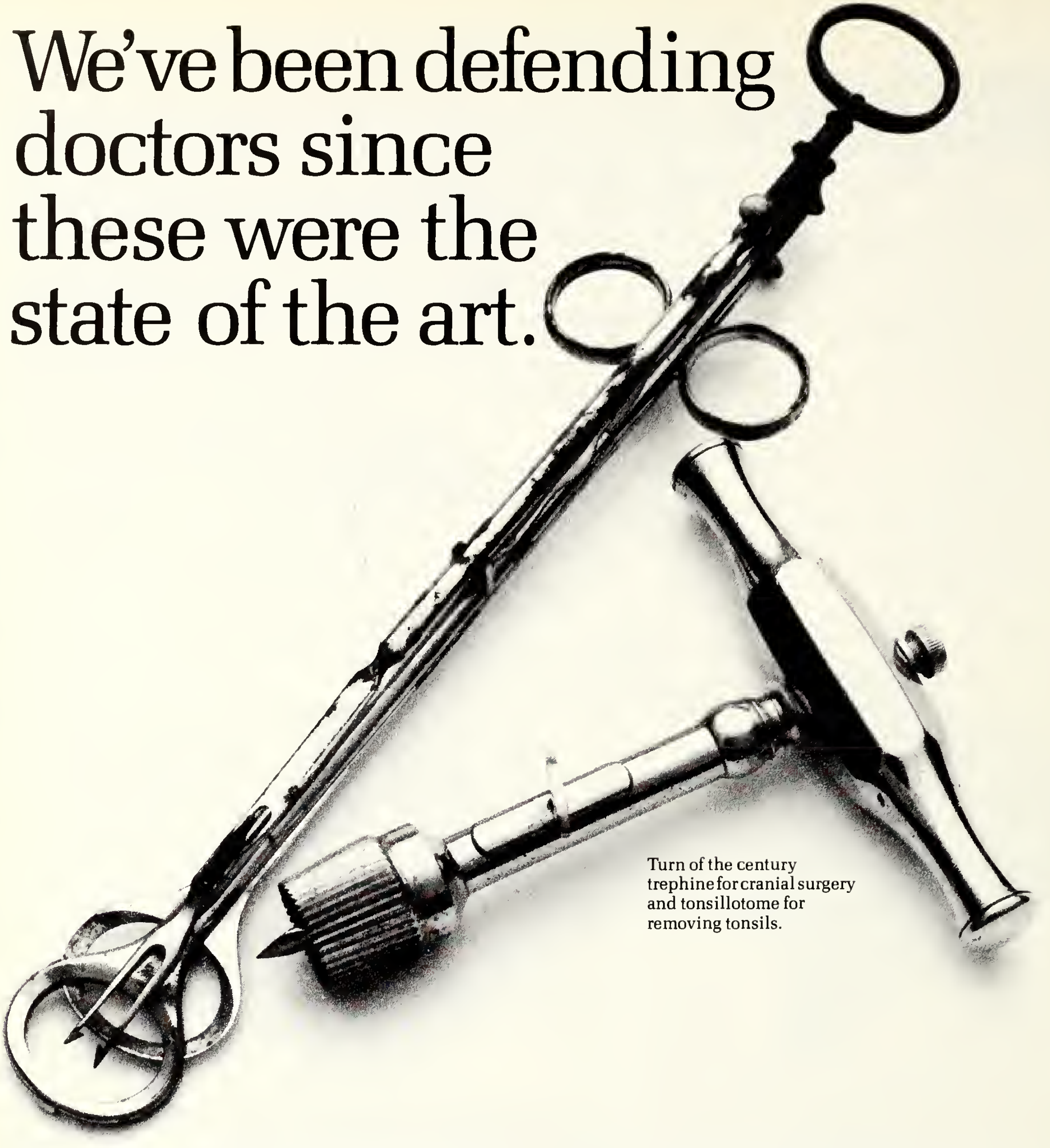

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Joseph Orr is a well-known Missouri artist. He finds his inspiration outdoors where he works to capture the light, texture and mood of a scene. It is this realistic style that makes his artwork unique. Mr. Orr's gallery/studio is located in Osage Beach.

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Lead Poisoning: It's Still Here

J. Regan Thomas, MD

You may have been like me. I thought lead toxicity had been eliminated with changes in paint products, unleaded gasoline, and widespread screening with the EP test. A recent study by the National Academy of Sciences reveals that more than 6 million preschool children and 400,000 pregnant women may have elevated lead concentrations. Lead poisoning, to the surprise of many, remains one of the more serious environmental health problems.

A recent study by the National Academy of Sciences reveals that more than 6 million preschool children and 400,000 pregnant women may have elevated lead concentrations.

Lead poisoning can be exhibited clinically by hyperactivity and learning disorders in children or accompanying CNS disorders. In pregnant women, a number of fetal developmental anomalies have been reported. Apparently, a lot of old lead-based paint still exists particularly in older homes and apartments. Another frequent source of contamination is the drinking water supply in homes with lead in the plumbing.

A significant problem developed in the screening process in recent years. The Center for Disease Control revised the allowable blood concentration for lead from 30 to 10 micrograms per deciliter. Unfortunately the most common screening test, the EP test (erythrocyte protoporphyrin) is no longer appropriate under the new guidelines. In spite of the ease and minimal expense of a finger stick blood test, the EP apparently is not accurate enough to be useful. Blood should be drawn and sent for laboratory analysis if lead exposure is suspected.

One of the more common causes of lead poisoning in adults as well as children is during home remodeling or repair. Most homes built before 1950 have lead-based paint as one of the original coats on walls, floors and woodwork. Any house built before 1978 could have lead-based paint. Renovation and paint removal may create hazardous dust, chips, fumes or vapors that can be unintentionally swallowed or inhaled. Another common source is still through the water supply in the home. Typically lead gets into the water after it leaves the treatment plant. Once the water comes into the house it may become contaminated through lead pipes or solder in the plumbing. Even many houses with copper pipes have lead solder at joints and connections which may be a source of lead contamination. In fact, lead solder is the major cause of lead contamination of household water in the U.S. today.

Like so many problems of this type, increased public awareness can be of significant importance toward improving the situation. If your patient population is at risk for lead exposure and you would like more information or help with home screening for them contact the National Lead Information Center (1-800-LEADFYI) or your county health department. ■

LETTERS TO THE EDITOR

To the Editor:

Please pardon my forthrightness, but "Violence in America: An Issue of Public Health" (Editor's Desk, October 1993) was editorial baloney. Such essays are too easily accepted at face value by today's physicians.

"Violence" (viz, homicide and serious injury by firearms) is a social problem, yes. A "public health" problem, no. Plainly and simply, physicians cannot stop this social problem. Neither can government stop it, except to obstruct its wanton portrayal on the screen, a maneuver certain to bring the ACLU screaming in protest to the public square. (Odd, isn't it? They're more than willing to confiscate handguns from law-abiding citizens, but unwilling to tolerate any significant attempt to arrest the pollution of the psyches of the nation's youngsters.)

Parents, on the other hand, can stop it.

Evidence is piling up that what youngsters see on movie and television screens does indeed affect their behavior (Etzioni A: *National Review*, October 18, 1993, pp 50-54). Why, then, do the entertainment mongers produce this violence-inducing garbage anyway? (Are you ready for this?) Because people eagerly watch it, including parents.

Parents don't, however, have to watch such garbage. Nor do they have to allow their children to watch it. Nor do they have to patronize theaters that show it or sponsors who pay for its transmission on television.

Thus, the only arena in which physicians can legitimately be expected to "take a leadership role in addressing violence in America" is in their own families.

Sincerely yours,
James L. Fletcher, Jr., MD, FAAFP
Cape Girardeau, Missouri

Dear Dr. Fletcher:

The editorial "Violence in America: an issue of public health" describes a trend of growing violence in our country. The message conveyed regarding this problem was that it is not simply an issue from the mean streets of the city, but has begun to invade other stations of our social structure including the hospital and physicians office. Your comments regarding confiscation of "... handguns from law-abiding citizens" and the ACLU seem extrapolated from perhaps some other personal concern you may hold, but are not reflective of anything stated in the editorial.

I am certainly in agreement with you that the motion picture and television industry should act more responsibly in the portrayal of violence. It seems clear to me that this contributes to violent behavior in some individuals and reinforces inappropriate acts as acceptable behavior to susceptible segments of our population.

I disagree with your characterization as "editorial baloney", the concern that the escalation of violence in America is a public health issue. Literally thousands of individuals are injured or killed by violent acts each year and the numbers are growing. As pointed out in the editorial, homicide is a principal cause of death in some demographic groups today. If one weighs costs from hospitalization and medical care related to this issue it has significant impact on health care economics. This violence in our communities threatens the health and well-being of our fellow citizens in the same fashion as toxins in our environment, poor nutritional habits or smoking, communicable infections, or other public health concerns.

Your assertion related to parents assuming responsibility and leadership within the family is one that I wholeheartedly share. I continue to disagree with your statement however that "the only arena in which physicians can legitimately be expected to take a leadership role in addressing violence in America is in their own families." As physicians we are often seen in our communities as concerned, credible citizens whose opinions and views are respected and considered. As a group, we should respond to that privilege whenever our skills or insights allow. Physicians have a tradition for compassionate leadership on behalf of their patients and communities. We should actively pursue concerns on this public health issue as we have done for many others in the past.

J. Regan Thomas, MD, Editor

Dear Editor:

I am sure that you have had many letters from retired physicians in reference to the bill passed by the Missouri legislature this Spring concerning the granting of a limited license to this discarded branch of the medical profession...old Doctors set out to pasture. I called the Board of Healing Arts and they said they would put my name on a list, but it will take time to formulate the correct wording of this limited license... that was two months ago. I hope they do a better job in writing this license than they did in their asinine affidavit for retired doctors to sign. I hope you have a copy of this great document. If you have a copy I would like to have your interpretation of what it entitles a retired doctor to do in his old age. After the Board of Healing Arts increased their legal staff and increased the cost of a license, I would think they could follow the law set down by the legislature and signed by the Governor and issue a limited license.

This is just a little example of what is in store for the medical profession when the Clinton Health Bill is passed, giving unlimited power to a few who will control the destiny of many.

I am glad that I have retired but would like to have this very limited license in order that I might give some medical advice to my family and help in community projects such as the Red Cross Blood Bank.

Sincerely,
M. P. Leech, MD, ***Fayette, Missouri***

Dear Editor:

It is time to create a structure that answers the challenges of the changing health care situation. The goals of controlling cost, quality, and access in health care are shared by physicians and patients.

Questions remain: will I be an independent professional advocating for the best choices for an individual patient or will I be reduced to a vendor owned and controlled by pervasive business or government interests whose primary motivation is bottom line result? Will I be a peer and have impact or an employee who executes practice parameters that I have little or no input in designing? Organized medicine at the state and local levels has been diligent in designing options to area physicians and patients which promote the former. "Clinics Without Walls" and "Physicians Directed Organizations" are demonstrated models with a proven track record in states such as California, Michigan, Minnesota, and Florida. The purpose of these groups is to enable physicians to maintain private practice independence and autonomy while coming together in a framework of health care delivery which promotes economy of scale.

GPWW (Group Practice Without Walls) is a single corporate entity owned by multi-office group practices or physicians who are geographically dispersed. The Board of Directors of the Clinic is elected by the peer partners. Contracting is pursued with third parties to provide health care to those eligible. The Clinic contracts with agents to give centralized administrative function and supply acquisition. A uniform fee schedule is set. Each physician's revenues go into a common bank account at a generally favorable rate. Top management is funded by monthly contributions. Physicians' salaries are based on their own generated revenue. A sophisticated computer system links offices for eligibility, referral, quality assurance, and outcome data. GPWW is a partially, yet substantially integrated network where doctors practice partly inside and partly outside the network while all data is tracked for outcome evaluation. Common billing, accounting, legal, payroll, personnel, group purchasing of office supplies, liability coverage, and banking services can provide savings from economy of scale. This design allows pooling of resources without full scale merger and the dominance that often follows from command centralization. Expensive brick and mortar costs are avoided, while geographic availability and convenience are preserved. Perhaps the most critical aspect of GPWW is that physicians share a single provider number (unlike PPOs, HMOs, and IPAs). During contract negotiations with third parties, most successful models have a ratio of 2/3 to 1/2 primary care providers to 1/3 to 1/2 sub-specialty mix. It is critical from the outset that participants share a cohesive group mentality and mission. Aggressive quality and utilization review is a true PEER process; doctor to doctor dialogue as opposed to our present day situation. These organizations properly executed have passed FTC evaluation and safe harbor parameters.

This model is not the best option for every doctor, and does not come free. Business autonomy is coapted to a group while onsite clinical independence is substantially preserved. Shared risk (as in a capitated format) in business integration must be real and substantial if anticompetitive sanction or economic failure are to be avoided. Start up capital ranges up to 2 to 10 thousand dollars per member to institute needed elements. This has been generally accomplished by financing at extremely favorable rates by lending institutions to avoid direct out of pocket expense. Employee benefit (retirement) plans may need restructuring to avoid possible disqualification under tax law. If one is used to solo practice, one suddenly finds one's risks and benefits at the fate of the group. The Minnesota model of GPWW is an example of real success with the goals as outlined. Most assembled legal opinions have stated that physicians have often been too timid in approaching innovative practice structures out of undue fears of being non-competitive in their actions.

The risks with this system approach are as real as the possibility of success. Whether physicians would be willing to invest the time, effort, and the capital equalling about half of the cost of their automobile to preserve their autonomy is an open question. Many of us in organized medicine feel that by remaining in existing practice modes, the autonomy of the physician-patient relationship and living standard are at a risk level of the highest experienced thus far.

Research of the needed resources has been assembled, and a core of motivated physicians are actively pursuing this goal. Watch for more information to be provided in future issues of *Progress Notes* and *Missouri Medicine.* Your local medical society can put you in touch with leaders in your area who are exploring this organizational possiblity.

Steven Buie, MD, ***Lee's Summit***

Holiday Cheer

SEASON'S GREETINGS

The following members of the MSMA Board and Council have contributed the cost of an hour or more of medical education to the American Medical Association Education and Research Foundation.

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The View from the Summit

Melvin C. Kasten, MD, MSMA President

> ... every time a new "plan to end all plans" comes to the forefront, about two-thirds of the people believe a better plan surely awaits them in the wings.

The Midwest Summit on Health Care Reform was held in Kansas City on October 29. It was telecast on C-SPAN and CNN, and its speakers included First Lady Hillary Clinton, Missouri Senators Danforth and Bond, and Kansas Senators Dole and Kassebaum. Also attending were numerous other Members of Congress, an impressive number of health care policy "experts," a vast array of government officials, staffers, and, of course, the secret service.

Although there are at least ten other major health reform bills pending before Congress, it is the Clinton plan at center stage in the national spotlight. The First Lady extolled her plan with great clarity of interest, but with a clouding of details. Artifice and equivocation are powerful tools in the hands of a skillful waverer, and wavering seems to be a trademark of this Administration.

On common ground among most of the health care plans is the call for portable universal coverage. Few would dare question the virtue of this imperative. But beyond that, principles and priorities vary wildly.

One speaker, Dr. Robert Blendon, from the Harvard University School of Public Health, offered a unique perspective on what ultimately is the fulcrum of all public policy debate: public opinion. Using sophisticated polling data, Blendon demonstrated that among Americans there is absolutely no consensus on health care reform. None. Never mind the Administration's slick media blitz. Never mind the insurance industry's equally slick counter-attack. And never mind that the press and news media have bludgeoned us all with a mind-numbing flurry of health care jabs and punches. The American public simply does not know what it wants and does not like any suggested changes. Blendon showed that every time a new "plan to end all plans" comes to the forefront, about two-thirds of the people believe a better plan surely awaits them in the wings.

This round robin of public distrust and indecision will continue, Blendon says, until the backers of one plan or another can explain their plan in terms that individual citizens care about and understand. Right now, that means providing details like how much more, or less, each individual can expect to pay for health care coverage; what benefits will be offered or taken away; and, what will happen to the relationship between the patient and his/her doctor. Coincidentally or not, these are the very questions that the Drs. Clinton seem unable (or unwilling) to answer.

The health care reform debate probably will begin in earnest within the next month or two, with most key decisions being made after the new year. What can we do? I suggest four things:

(1) Contact your Senators and Representatives in Washington, D.C. Let them know you are watching and that you are available to answer questions.
(2) Talk to your patients about health care issues.
(3) Get involved in the political process and support the candidates that represent your views.
(4) Get active in the AMA, the MSMA, and your local medical society.

The voice of medicine represents you, your profession, your practice and, most important of all, your patients. Active and united, it is a voice that will be heard and understood. When public opinion does finally coalesce on health care reform, don't you think it vital that we play a key role?

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Practice Strategies for Coping with "Reform"

Danielle Halsel

Almost without a doubt, health care reform will happen. Whether it comes through the federal or state government or through the marketplace, it will happen. And the way it looks now, its construction will be based on cost-control and quality.

So how do you position your practice? What is your best strategy?

Practices which will be most successful are those which assess the health of their practice now, and position themselves to be able to respond to changes as they evolve. The best positions are developed by those who are informed. Take the time to regularly monitor the issues, and analyze them not only from your perspective, but from the perspectives of patients and policy-makers.

Critical to survival will be the development of strategic alliances. Physician affiliations with other physicians, hospitals, managed care organizations, and employers will become increasingly important as integrated systems, whether formal or informal, will best be able to handle the challenges ahead. To prepare for those possibilities, physicians must take the vital signs of their practice in order to identify areas where improvement can be made and savings can be realized.

Assess the Health of Your Practice

- Begin by conducting an operational analysis using qualified professionals. Specifically review for practice productivity, financial policies, staffing, risk-management and adherence to office policies.

- Ensure all staff members have written job descriptions and accountability for each task performed. The logical tool to accompany this is an objective appraisal system including criteria for clinical and service standards.

- Analyze your written office policies and procedure manuals. If the practice does not have manuals for the front- and back- office, develop them as soon as possible by having each staff member write (or dictate) steps involved for each task performed. Review this listing to ensure the description is the most efficient mechanism possible.

- Review your practice's budget against industry standards, investigate areas of discrepancy, and make changes where they are indicated. Industry standards provide the physician a good gauge of how the practice compares. Look directly into the non-essential expenditures, and whether you are taking advantage of options such as bulk-purchasing.

- Identify mechanisms to further increase productivity. Equipment, such as computers, can increase productivity, but equally important are your day-to-day procedures. Create an office environment where the staff can "think through" alternate, but more effective ways to accomplish the same goals.

- Understand how your practice is being perceived. Survey (either formally or informally) your patients, staff and colleagues. Know what your data is telling others by critically reviewing your frequency reports. Take a hard look at your office systems with the understanding that as more and more emphasis is being placed on the "efficient provider," the practice needs to know exactly how it is being perceived.

Health reform will reward cost-effective quality care. Practices which are costly or inefficient, who are not able to document significant differences in patient outcome will see their revenue base dwindle. Consequently, physicians need to take advantage of the small window of opportunity to get their house in order.

If you have questions for Danielle Halsel, write to Practice Management, c/o ***Missouri Medicine****, P.O. Box 1028, Jefferson City, MO 65102 or call her at (913)541-0050.*

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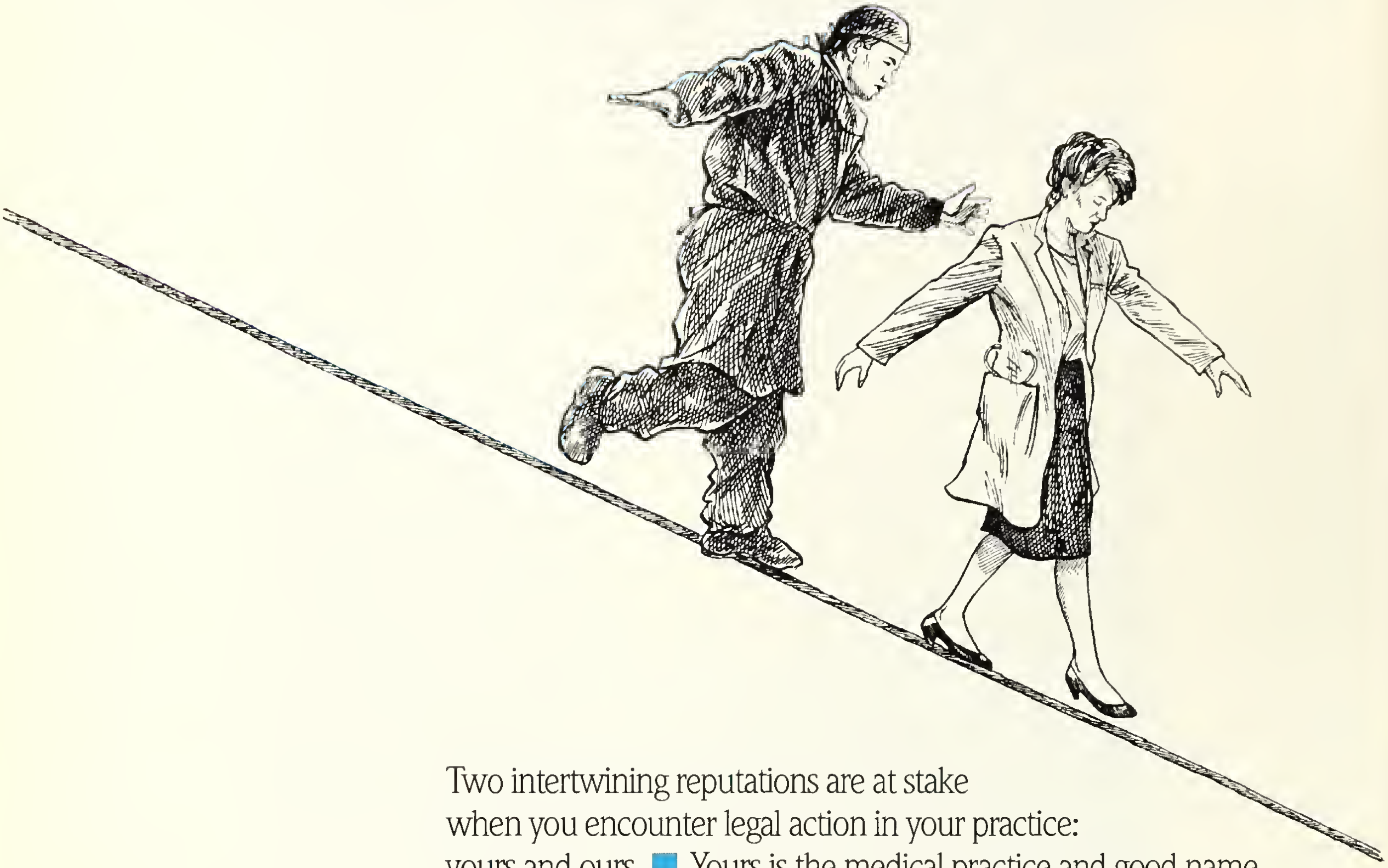

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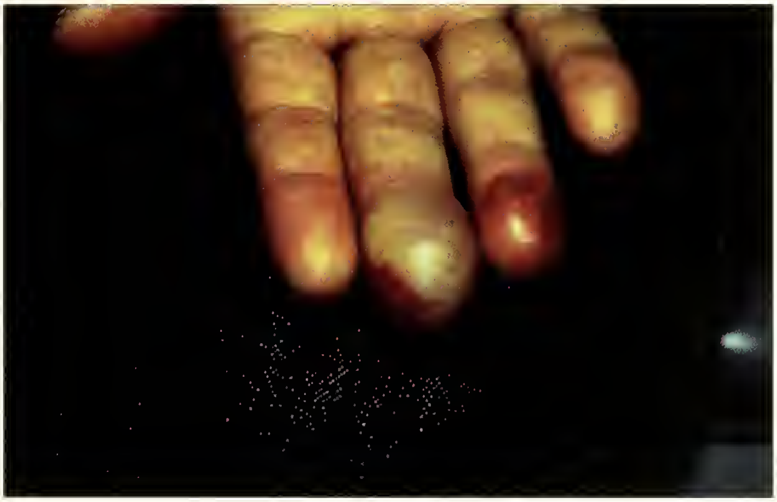
Dermatology Quiz #9



This 50-year-old man presents with a two-day history of these painful skin lesions.

1) **Your best diagnosis is?**

   a. frostbite
   b. cholesterol emboli
   c. Raynaud's disease
   d. cryoglobulinemia

2) **Appropriate treatment at this point may include?**

   a. ice packs and elevation
   b. surgical debridement
   c. analgesics
   d. tetanus booster

(See Answers on next page.)

DERMATOLOGY QUIZ ANSWER

(Dermatology Question is on previous page.)

Answers:

1) a. frostbite
2) c. analgesics, and d. tetanus booster

Frostbite has been a major medical problem for military personnel throughout the ages. It is also common among those who enjoy mountain sports such as hiking and cross-country skiing; however, the persons most at risk are those who suffer from psychiatric illness or alcoholism. Peripheral vascular disease, tobacco use and previous frostbite injury are also predisposing factors.

Frostbite usually occurs at temperatures under 0°C and higher wind velocities make freezing more likely because heat is lost through both radiation and convection. During freezing, ice crystals are formed in the extracellular space and cells undergo dehydration. Damage to the endothelial lining of the arterioles leads to vascular thrombosis and subsequent tissue anoxia. On rewarming, tissue damage results from oxygen free radical generation and vasoconstriction mediated by prostaglandins.

A variety of classification schemes for frostbite have been suggested. In general, the term "frostnip" refers to cold exposure characterized by transient pallor and pain without permanent sequelae. "Frostbite" refers to actual freezing of the tissues. The skin is white or erythematous and firm with superficial frostbite but the underlying subcutaneous tissue is moveable. Edema, bullae and eschar formation may be seen. With deeper injuries, the subcutaneous tissues are not pliable. The skin may be red, mottled or cyanotic and necrosis of the skin, subcutaneous tissue, muscle, tendon and even bone may result.

The gold standard of therapy for early frostbite injuries is rapid rewarming in water at 40°C. Rewarming should not take place where there is any danger of refreezing. A second freeze causes much more damage than a single freeze-thaw cycle. Standard therapy also includes bed rest, splinting and elevation of the affected body part, tetanus toxoid for prophylaxis if needed, and analgesics for the usual intense pain.

Some centers give antibiotics for prophylaxis and some give ibuprofen to inhibit the production of inflammatory mediators (thromboxane & PGF_2). Neither of these treatments has been supported with controlled trials.

Early surgical intervention is contraindicated. Frequently, tissue loss will be less at 6 to 8 weeks than was initially anticipated. Once the necrotic tissues are clearly demarcated, debridement and reconstruction can be performed.

Long-term complications of frostbite include premature growth plate fusion in children, hyperesthesias, hypopigmentation, and hyperhidrosis as well as predisposition to future frostbite.

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This Dermatology Quiz is submitted by Karen Zanol, MD, Clinical Instructor, Division of Dermatology, University of Missouri-Columbia.

The Dermatology Quiz is coordinated by Philip C. Anderson, MD, Professor and Director at the University of Missouri in the Division of Dermatology.

PROTECTING PENSION PLANS ... What's A Doctor To Do

Sharon R. Davisson, CPA

With the winds of change in the health care system now blowing even stronger, words like *competitive, managed, allied, HMO, PPO,* and *care center* appear to be defining future health care for all of us. Out of this windstorm, hospitals are announcing newly-formed alliances...can the doctors be far behind?

Doctors are paying attention to health care proposals and wonder what their place will be in the future care of patients. Doctors hope they can still be working for the patient, but know they will be basically working for health care organizations. To practice medicine in the next ten years, a doctor will have to pay even more attention to the business side of the practice by lowering overhead costs while still trying to provide the same quality of patient care. As a new health care system takes on more definition, that same doctor may have to consider giving up autonomy and joining with a group of physicians, merging practices, selling his/her corporation, and/or going to work for another entity.

We all know about the pitfalls of taking in an associate, buying into a partnership or a corporation. One pitfall, which is usually mentioned only in passing or as a footnote, is what to do with pension plans in mergers or sales.

Different forms of practice sales and mergers can take place. Likewise, different risks and liabilities are assumed by the parties in sales and mergers. Doctor Buyer can purchase stock and will automatically assume the acquired corporation's liabilities (both known and unknown), or he can purchase assets, and the liabilities remain with Doctor Seller unless Doctor Buyer assumes them. However, in any sale, the financial dangers are most significant for the buyer. For example, unfunded pension liabilities can be large amounts and Doctor Buyer will have to fund them. In a merger, all shareholders assume risks.

While not all permutations of retirement plans, mergers, and terminations can be covered in a single article, here are some more common situations to consider.

At some point in the buy/sell or merger negotiations, discussions will center on pension plans. Usually the plans will not be compatible and, in reality, only about 10% of plans merge. Doctor Older may have a defined benefit plan, which can have unfunded liabilities. Doctor Younger may have considered this kind of plan, but he has too many family obligations to even consider funding a defined benefit plan. Doctor Younger has a SEP (Simplified Employee Plan) which works for him and his employees, and he can decide once a year on the amount of cash that is available to fund this simple retirement plan.

What is a doctor to do?...pay attention to the rules. **BE AWARE OF *ERISA*** (Employee Retirement Income Security Act of 1974), COBRA (Comprehensive Omnibus Budget Reconciliation Act of 1986), the Internal Revenue Service, court cases, and all other governing laws. The basic rules to remember are fairness to employees and participants' rights.

> "Plan participants must receive comparable or greater benefit when plan merges or consolidates with another plan, or when plan assets and liabilities are transferred to another plan.
>
> Participants' rights to funded accrued benefits or amounts credited to their accounts are non-forfeitable when a plan is completely or partially terminated or when contributions are discontinued. Defined benefit plans must meet nondiscrimination requirements at termination."[1] Also at, "termination pension plans triggers immediate vesting."[2] This means Secretary Overworked who is too young to retire has a non-forfeitable right to the amount credited to her account. It may not be what Doctor Seller intended, but it is the rule.

Two doctors **cannot** merge their practices and allow each to keep their own employees and their own pension plans. The new corporation must treat all employees equally. Although employee benefit plans such as health insurance are not discussed here, the same rules apply: all employees must be treated equally. This is not to say part-time employees have the same rights as full-time employees.

So before a merger occurs, Doctor Older will want to end his **defined benefit** pension plan. Doctor Younger will be wise to audit the defined benefit plan so potential underfunding is not lurking about thereby relieving himself of assuming unknown liabilities when Doctor Older and Nurse Tired retire. In turn, Doctor Older will want to know if overfunding in his plan has occurred. Plan assets that come back into the corporation are subject to a non-deductible excise tax.

Suppose Doctor Older and Doctor Younger both have **defined contribution** plans. If they merge the plans, again, the fairness rule requires that, "On the merger or consolidation of two or more defined contribution plans, the account balances of each participant immediately after the merger must equal his account balance immediately before the merger."[3] In other words, you cannot decrease employee account balances or benefits.

One common pension solution in a merger is to cap or terminate prior plans and start a new plan. A profit-sharing plan variation known as WAVE (Weighted Average) that has been available since 1990, distributes contributions based on compensation level and age. This is known as an age-weighted profit-sharing plan.

Greater contributions can be made for persons who are closer to retirement. Other advantages to the WAVE are: age-weighted plans do not have to be funded each year; PBGC (Pension Benefit Guarantee Corporation) premiums do not have to be paid; finally, these plans can be set up by sole proprietors, partnerships, and S and C-corporations. Thus, Doctor Older, Doctor Younger, and their employees can all benefit.

This article is not intended to be all-encompassing, but rather to assist the physician in asking the right questions when changing his/her form of practice. It does not covered ESOPS (Employee Stock Ownership Plan), deferred compensation plans, employee benefit plans (cafeteria plans, health, life, dental, disability, insurance plans, etc.). When considering major changes, consult professionals who are experts in their fields. A poorly planned and executed merger or sale can cost you dearly for years.

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SPECIAL SERIES: Chronic Disease Reports

Racial Differences in the Prevalence of Cardiovascular Risk Factors Among Persons with Diabetes

Angelia Y. Weaver, MPA, Ross C. Brownson, PhD, Joan C. Wilkerson, BA, Patrick O. Akinbola, PhD, and Jeannette Jackson-Thompson, PhD, MSPH

Persons with diabetes are at greater risk of numerous health complications including coronary heart disease and stroke. We used telephone survey data to assess racial variations in the level of cardiovascular risk factors among Missouri diabetics. The four risk factors included physical inactivity, obesity, hypertension, and cigarette smoking. Each risk factor except smoking was more common among persons with diabetes than among non-diabetics. In addition, these risk factors were more common among Blacks than among Whites. Our results suggest the need for expanded efforts at controlling diabetic complications among person at high-risk.

INTRODUCTION

Diabetes mellitus is characterized by the presence of abnormal amounts of sugar in the blood. Insulin enables the body to store and burn the sugar in food properly. When the pancreas does not produce enough insulin, the body cannot use or store sugar normally. About 14 million Americans have diabetes, of whom seven million have been diagnosed and a similar number have the disease unknowingly. Each year, more than 650,000 new cases of diabetes are identified.[1]

Individuals with diabetes face not only a shortened life span, but also the probability of developing acute and chronic complications. Untreated diabetes can cause a variety of complications such as cardiovascular disease, eye disease (retinopathy), and decreased blood circulation and nerve damage (neuropathy) in the limbs resulting in lower extremity amputations. Diabetes increases the risk of heart disease and stroke approximately three-fold and increases the risk of peripheral vascular disease approximately five-fold.[2]

Among Blacks, there are an estimated 1,075,000 who are known to have diabetes. Approximately 3.6% of all Blacks have diagnosed diabetes, compared with about 2.8% of Americans overall.[1]

Diabetes is the seventh leading cause of death in the White population and the sixth leading cause of death in the Black population. In 1992 in Missouri, diabetes accounted for 1,080 deaths as the underlying cause and 2,600 deaths as a contributing cause.[3]

An earlier *Missouri Medicine* article examined the prevalence and patterns of diabetes in Missouri.[4] To evaluate the prevalence of several cardiovascular risk factors among diabetics in Missouri, we utilized telephone survey data collected through the Behavioral Risk Factor Surveillance System (BRFSS).

METHODS

The BRFSS was developed by the Centers for Disease Control and Prevention to assist state health departments in the measurement of modifiable risk factors.[5-7] The BRFSS uses a cluster sampling and random-digit dialing technique[8] to select adult (≥ 18 years of age) Missourians for telephone interviews. Beginning in the second week of each month, potential respondents are called until 126 interviews are completed.

To examine patterns in four important cardiovascular disease risk factors (i.e., physical inactivity, obesity, high blood pressure, and cigarette smoking),* we analyzed BRFSS data collected between January 1988 and June 1993. The total sample size over the period was 8,166. This included 457 respondents who said they had been told by a doctor that they had diabetes. Our sample included only 60 Blacks with diabetes.

Continued on page 752

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* Definitions of risk factors used in BRFSS: physically inactive: respondents reported fewer than three 20-minute sessions of leisure-time physical activity per week; obesity: a body mass index (BMI = weight [kg]/height [m^2]) ≥ 27.8 for men and ≥ 27.3 for women; high blood pressure: respondent has been told that blood pressure is high; cigarette smoking: respondents reported currently smoking cigarettes.

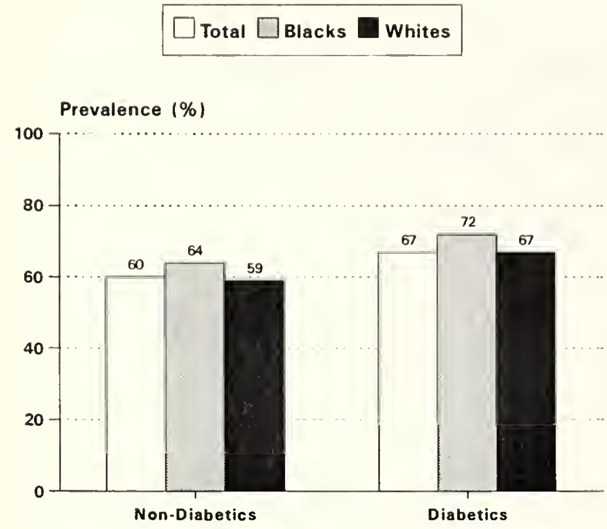

Figure 1. Prevalence (%) of physical inactivity among Missouri adult diabetics (1988-93), by race.

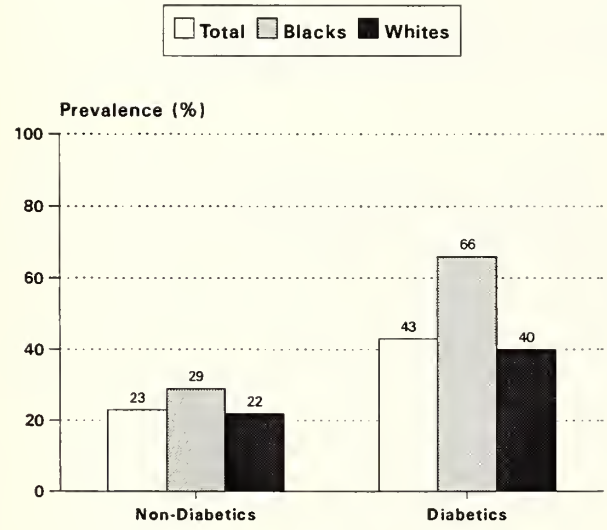

Figure 2. Prevalence (%) of obesity among Missouri adult diabetics (1988-93), by race.

Continued from page 751

Data were analyzed using the programs of SAS[9] and SUDAAN.[10] The data were weighted for the respondents' probability of selection as well as to the age-, race-, and gender-specific population counts from the most recent Missouri census.[5-7] SUDAAN, a program for analyzing complex survey data, was used to produce the standard errors of the prevalence estimates.[10]

RESULTS

Figure 1 illustrates the prevalence of physical activity among persons with and without diabetes. Of the total Missouri non-diabetic population, 60% was physically inactive, compared with 67% inactivity among persons with diabetes. Among Black persons with diabetes, physical inactivity was more common than in any other subgroup (72%).

Figure 2 shows that the prevalence of obesity was much higher among persons with diabetes than among persons without diabetes (for the total population: 43% *versus* 23%). In addition, obesity was more common among Black persons with diabetes (66%) than among White diabetics (40%).

As shown in Figure 3, the prevalence of self-reported hypertension was approximately three times as common among persons with diabetes than among non-diabetics. The highest prevalence of hypertension was reported among Black persons with diabetes (75%).

Among the Missouri non-diabetic population, cigarette smoking prevalence was equivalent among Blacks and Whites (Figure 4). However, among persons with diabetes, smoking was less common among Blacks than among Whites (12% *versus* 18%).

DISCUSSION

In this report, we examined four major risk factors for cardiovascular disease--physical inactivity, obesity, hypertension, and cigarette smoking. Each risk factor except smoking was more common among persons with diabetes than among non-diabetics. In addition, these risk factors were more common among Blacks than among Whites.

A wide range of health complications is more prevalent in persons with diabetes than in non-diabetics (see Appendix Table). Among the most common of these complications are stroke, coronary heart disease, blindness, and end-stage renal disease.[13,14] Modifiable risk factors such as obesity, hypertension, and cigarette smoking interact with diabetes to greatly increase the risk of these diabetic complications. As illustrated in our data, Blacks are particularly at risk for such complications.

The American Diabetes Association maintains that half of all non-insulin-dependent diabetes cases and at least half of most major complications of diabetes could be prevented by appropriate education and intervention programs that can help diabetic persons control obesity, reduce cholesterol levels, increase physical activity, stop smoking, lower blood pressure, and improve control of their blood-glucose levels.[15] Active intervention by health practitioners is vital in reducing diabetic complications among high-risk patients. An excellent guide, *The Prevention and Treatment of Complications of*

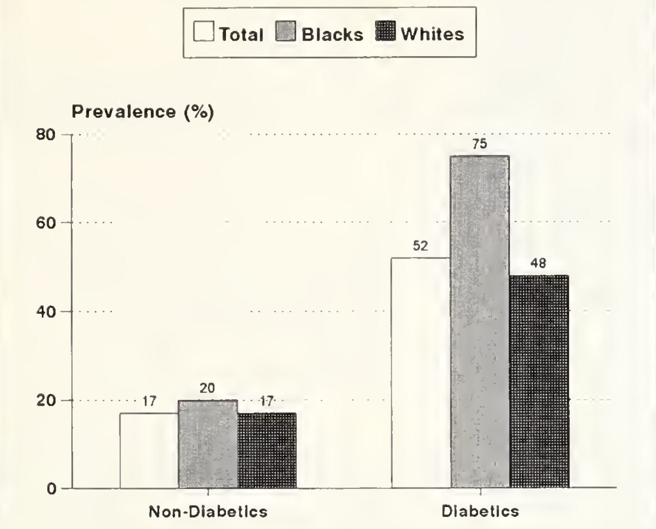

Figure 3. Prevalence (%) of high blood pressure among Missouri adult diabetics (1988-93), by race.

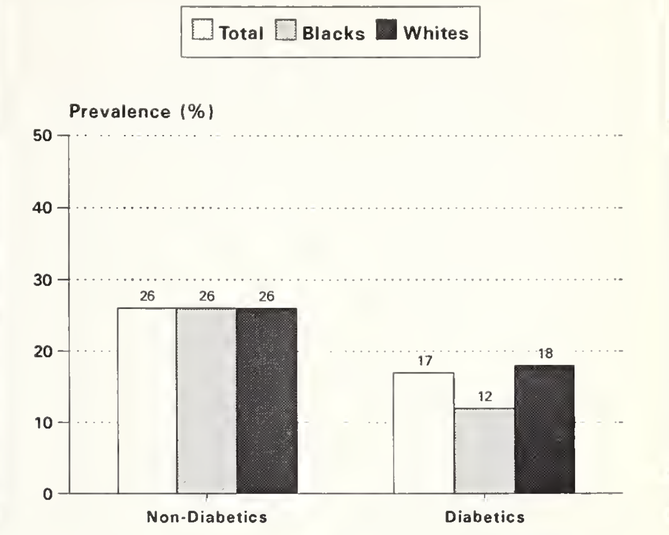

Figure 4. Prevalence (%) of current cigarette smoking among Missouri adult diabetics (1988-93), by race.

Diabetes: A Guide for Primary Care Practitioners,[2] is available free of charge from the Missouri Department of Health.

Public health efforts are underway to address cardiovascular risk factors among diabetic populations. The Missouri Diabetes Control Program, funded by the Centers for Disease Control and Prevention, is working with public health agencies in St. Louis, Kansas City, and southeastern Missouri to reduce diabetic complications among high-risk populations. The focus of the current program is clinical management of diabetic eye disease and vascular complications, as well as elimination of modifiable risk factors such as hypertension and smoking. The Missouri Department of Health has proposed a targeted health initiative to supplement and expand current efforts.[16]

Our study is limited by the self-reported nature of the data collected through the BRFSS. This surveillance system oversamples older White middle class women and undersamples minorities and other hard to reach populations who may have limited phone coverage. This may result in underestimation of risk factor prevalence.[5] Because of sample size limitations, we could only make racial comparisons for Blacks and Whites, even though diabetes prevalence is also elevated among Hispanics and Native American Indians.[12] Our analysis did not adjust for socioeconomic status, which may explain much of the racial differences noted.

Despite these limitations, our data indicate that persons with diabetes in Missouri, particularly Blacks, are at greatly increased risk of cardiovascular disease. The need for focused and effective interventions in these populations is apparent from our study.

Acknowledgments

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Appendix Table - Summary of risk factors for complications of diabetes*

Factors / Complications	Age (y)	Sex	Race	Obesity	Lack of Self-Management Skills or Access to Care	Hypertension	Cigarette Smoking	Hyperlipidemia	Hyperglycemia
KETOACIDOSIS	Maximum at < 45	F > M	Other races> white	?	+ +	_	_	_	+ +
CONGENITAL MALFORMATION	Increases with age of mother	F only	Other races > white	?	+ +	_	_	_	+ +
STROKE	Increases with age	F > M	Other races = white	+ +	+	+ +	+	+	+
CORONARY HEART DISEASE	Increases with age	M > F	Other races = white	+ +	+	+ +	+ +	+	+
PERIPHERAL VASCULAR DISEASE	Increases with age	M > F	Other races = white	+ +	+	+	+ +	+	+
BLINDNESS	Maximum at > 65	F > M	Other races > white	+	+	+	_	_	?
END-STAGE RENAL DISEASE	Maximum at < 45	M > F	Other races > white	+	+	+ +	?	_	?
AMPUTATION	Increases with age	M > F	Other races > white	+	+	+	+ +	+	+ +

*Adapted from references 11 and 12.
(? = possible risk factor.) (+ = risk factor.) (+ + = major risk factor.) (- = not a risk factor.)

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Grateful Med and Loansome Doc: Easy Access to the World's Biomedical Literature

Karen M. O'Keefe and MaryEllen C. Sievert, PhD

For many years MEDLINE, the large, international database of the biomedical literature, was available to the biomedical community only through experienced searchers who mysteriously were able to retrieve from the literature the information to fulfill the physician's information need. Searching the literature yourself was time-consuming and costly. In 1986, however, the National Library of Medicine changed the situation and any health care practitioner can now do his or her own searching from the office or home. The tool that makes this access possible is Grateful Med. Grateful Med is an innovative program which makes it easy for even a novice searcher to electronically cull the literature for the information he or she needs. However, knowing that an article which answers the questions exists is little help unless there's a way for the physician to obtain a copy of that article. Loansome Doc, also developed by the National Library of Medicine, provides just that opportunity. Together these two programs mean that any health care professional, anywhere in the country, has access to the millions of articles published in any area of health care.

Dr. Saty Satya-Murti[1], a physician user, provides these guidelines for using literature searching:

When Do I Use Computer Searching?

1. When the patient's condition is complicated, difficult, or not common.
2. In a situation where there may be new trends in therapy; for instance management of medication.
3. To update a procedure I have done in the past but am not presently using.
4. While preparing a manuscript for submission to a peer-reviewed journal.

Grateful Med provides physicians with the means to perform these types of literature searches. Why is Grateful Med so valuable in this setting? The Grateful Med software connects via modem to the National Library of Medicine's MEDLARS system to access MEDLINE and other databases. It alleviates the need to know how the National Library of Medicine indexes material or the search commands that a professional searcher of the medical literature would use. Also, an entire search can be entered without much understanding of Boolean concepts (the combining of terms through the use of "and", "or", or "not"). Furthermore, the entire search is formulated on the physician's personal computer allowing her or him to think about the best terms to use without having to worry about the costs. That is, only the completed search is run online so that the user pays only for the time the MEDLARS computer is searching. After the search is finished the user can review and edit the search. Personnel at the National Library of Medicine estimate that, with the reduced online charges which began in January 1993, the average Grateful Med search costs only about $1.21. The cost of the software is only $29.95. As Grateful Med is improved, all Grateful Med users receive each update of the newest version (currently version 6.0) at no additional cost. In addition, users receive a newsletter, *Gratefully Yours* which keeps them aware of the new developments. There are currently over 40,000 subscribers to Grateful Med.

What equipment does the health care professional need to use Grateful Med? In addition to a computer with a hard disk with at least 2.5 Mb space, DOS version 3.0 or higher and 512Kb of RAM are required (though 640Kb RAM is recommended). Grateful Med will also work with a Macintosh microcomputer. Under development is a version of Grateful Med which will run on a UNIX workstation. In addition a modem, which translates the signals from the computer into signals which can be transmitted over telephone lines, is also needed. The faster the transmission speed of the modem, the cheaper the searching will be so a little extra money on the modem will result in savings in the long run.

Once the computer is set up, just how much computer expertise does a potential Grateful Med user need? Grateful Med is designed so that the user need only know how to start the program and to read the information on the various screens. That is, little formal knowledge of computers is needed. A screen appears asking if the user would like to search MEDLINE, or other databases. If the user selects Other, 19 other MEDLARS databases are made available for the user to select. Throughout the interaction, the program prompts the user. In addition, the various function keys have been programmed to make searching the system easy. When the search formulation is complete, a single keystroke will establish connections with the NLM computer. Version 6.0 also allows users to see Clinical Alerts, containing information "deemed by the National Institutes of Health (NIH) to be of special importance." Clinical alerts are items considered so important that the regular publication route is too slow. Users of MEDLINE, then, see these very important announcements when they connect to the computer.

For those unaffiliated with a hospital, Loansome Doc, the companion to Grateful Med, is another valuable piece of software. Loansome Doc provides to the user full-text photocopies of the citations from MEDLINE and several other databases. Once the physician has selected the articles in which he/she is interested, the complete photocopied text of the selected citations can be received via mail, FAX, or pickup, as the user prefers. This novel feature of Grateful Med enables the physician in a remote rural setting to have the same access to the medical literature as the physician at a large research-oriented medical center.

In order to use Loansome Doc, one must first sign an agreement with a medical library that uses DOCLINE, the National Library of Medicine's interlibrary loan and referral system. After the physician fills out an application from one of these libraries agreeing to abide by copyright law, he/she is given a library ID. Then the user must configure the user screen, storing complete name, address, telephone number, fax number, the library ID, and the preferred method of receiving photocopies of the articles selected (by fax, mail, or pickup). This library will also arrange the procedure for payment for the physician. The user of Grateful Med may then select citations through Loansome Doc and with a keystroke these requests are sent electronically to the National Library of Medicine, which relays these requests to the user's nearest DOCLINE supported library. This library then sends the user the full-text photocopies. In Missouri, such resource libraries are the J. Otto Lottes Health Sciences Library at the University of Missouri-Columbia Health Sciences Center, the Washington University School of Medicine Library, and the St. Louis University Medical Center Library.

Although Loansome Doc was first made publicly available in 1992, it uses DOCLINE which has existed for years to do interlibrary loan for medical libraries. Loansome Doc simply makes the process easier and faster, by making the user's resource library responsible for filling or, if the user prefers, referring requests to another library if the user's library cannot fill it. The charge for this service is usually comparable with other interlibrary loan request charges -- about $7.00 at J. Otto Lottes Health Sciences Library. Most of the Grateful Med users using Loansome Doc through Lottes Health Sciences Library are in small communities such as Moberly or Eldon.

Says Christopher D. Smith M.D. of the rural outreach aspect of Loansome Doc,

> "I think Loansome Doc is the single most important service offered by the NLM... It comes very close to my paradigm for data access, which should be to have the entire National Library of Medicine... available in my home."[2]

Those wishing to learn more about Grateful Med and Loansome Doc may call the MEDLARS Management Service Desk at the National Library of Medicine at (800) 638-8480 or write the Grateful Med Coordinator at National Technical Information Service (NTIS), 5285 Port Royal Road, Springfield, VA 22161. Those wishing to call NTIS may do so at (703) 487-4807.

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Survival Following Breast-Conserving Surgery and Irradiation or Modified Radical Mastectomy in Patients with Invasive Breast Cancers with a Maximum Diameter of 1 CM

Karen J. Halverson, MD; Marie E. Taylor, MD; Carlos A. Perez, MD; Robert Myerson, MD; Gordon Philpott, MD; Joseph R. Simpson, MD; George Tucker, MD; and Carol Rush

The reported relapse-free survival for women with invasive breast cancers measuring no more than 10 mm in dimension ranges from 75% to 95%, with axillary status an important prognostic factor in most series. Further study of prognostic variables in this most favorable subset is notably limited. We retrospectively reviewed the records of 168 women with invasive breast cancers ≤ 10 mm treated with either breast conserving surgery + axillary dissection (AXD) and radiation therapy, or mastectomy + AXD. The actuarial survival and survival free of distant metastases (DMFS) at 7 years was 95% and 97%, respectively. Location and size of the primary tumor were most important in predicting outcome, although statistical significance was not achieved. The 5-year distant metastases-free survival (DMFS) was 100% for central and inner quadrant tumors, compared to 97% in those with outer quadrant tumors, p = 0.18. The 5-year DMFS was 100%, 95%, and 98% for patients with cancers 2-5 mm, 6-9 mm, and 10 mm, respectively, p = 0.15. Status of the axillary lymph nodes, type of breast surgery, clinical tumor status (palpable vs. nonpalpable), age, menopausal status, histologic grade, systemic therapy, or histologic type were not found to have a significant impact on prognosis.

INTRODUCTION

With greater awareness of the importance of early detection of breast cancer,[1-3] very small cancers are becoming more commonplace.[4] Information regarding these most favorable cancers is usually found under the broad categories of "minimal breast cancer" or "clinically occult" cancer, i.e., detected by mammography alone or incidentally found after biopsy of a benign lesion.[4-10] Many reviews concerning minimal breast cancer have been published, and include patients with lobular carcinoma in situ, ductal carcinoma in situ, as well as invasive cancers with a maximal dimension of 5 to 10 mm, depending upon the author's preference.

Obviously, the inclusion of both in situ and invasive cancers engenders a very heterogeneous group of patients. It has been suggested that these three entities, i.e., lobular carcinoma in situ, ductal carcinoma in situ, and small invasive cancers, be considered separately.[11] To this end, the following study was undertaken to determine clinical characteristics, patterns of failure, prognostic factors, and survival in patients with invasive cancers with a maximal diameter of 10 mm.

METHODS AND MATERIALS

Between January 1, 1958 and December 31, 1988, 145 patients with invasive cancers no more than 10 mm in greatest dimension were treated with breast conserving surgery with and without axillary dissection, followed by radiation therapy at Mallinckrodt Institute of Radiology and affiliated hospitals. In addition, between January 1, 1985, and December 31, 1988, 23 patients with invasive breast cancers measuring no more than 1 cm were treated at one of the affiliates (St. Luke's Hospital) with mastectomy with or without axillary dissection and no post-operative irradiation. The clinical characteristics of the study population is shown in Table 1.

The median age at diagnosis was 59 years (range, 29 to 84 yrs.). Axillary dissection was performed in 138 patients (82%); the median number of lymph nodes removed was 14 (range, 0 to 39).

The details of the radiation have been previously described[12]; briefly, all patients undergoing conserva-

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Table 1 - Characteristics of the study population.

	Number	%		Number	%
Tumor Size			Mammography		
< 3 mm	10	6%	Negative	16	10%
4-6 mm	31	18%	Positive/Suspicious	126	75%
7-9 mm	50	30%	Not done	8	5%
10 mm	77	46%	Unknown	18	10%
Menstrual Status			Location		
Pre-menopausal	30	18%	UOQ	72	43%
Peri-menopausal	10	6%	LOQ	16	9%
Post-menopausal	125	74%	UIQ	38	23%
Unknown	3	4%	LIQ	14	8%
Histology			Central	23	14%
Invasive ductal	155	92%	Unknown	5	3%
Invasive lobular	9	6%	Age		
Other	4	2%	< 50 years	36	21%
Grade			> 50 years	132	79%
Well differentiated	36	21%	Estrogen Receptor		
Moderately differentiated	17	10%	ER+	51	30%
Poorly differentiated	13	8%	ER-	12	7%
Unknown	102	61%	Unknown	105	63%

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tive surgery received postoperative breast irradiation via tangential fields utilizing 1.25 MeV - 6 MV x-rays; occasionally an obese patient was treated with 18 MV x-rays. The tumor bed was almost always boosted with either an interstitial implant or electrons. The extent of nodal irradiation was at the discretion of the attending radiation oncologist.

Adjuvant systemic therapy was administered in 27 patients, and consisted of chemotherapy + hormonal therapy in 9, and hormonal therapy alone in 18. The administration of systemic therapy by axillary lymph node status is shown in Table 2.

Table 2 - Administration of systemic therapy by axillary lymph node status.

Lymph Node Status	Number	Chemotherapy ± hormonal therapy	Hormonal Therapy	None
Negative	121	1	8	112
Positive	17	8	5	4
Undissected	30	0	5	25
Total	168	9(5%)	18(11%)	141(84%)

Follow-up time and time to failure was calculated from the date of diagnosis. The median follow-up time of living patients was 55 months (range, 36 months to 195 months). Follow-up information was obtained from the charts in the Radiation Oncology Center, from the referring physicians, or occasionally by direct contact with the patient or her family. Follow-up information was available in all but one patient.

Survival curves were generated using the life table method of Cutler and Ederer,[13] and statistical differences between comparison groups were determined by the generalized Wilcoxon (Breslow) Method or Pearson chi square.[14,15]

RESULTS

The actuarial survival and survival free of distant metastases for the entire study population is shown in Figure 1. Five have died; 1 of breast cancer and 4 of intercurrent disease. Because only one patient died of breast cancer, prognostic factors were evaluated with distant metastases-free survival (DMFS) as the end-point, as shown in Table 3.

One hundred thirty-eight had axillary dissection (AXD); thirty women did not, because either the patient was thought to be too old, or because the tumor was so small that the probability of axillary metastases was considered too small to justify the risk and sequelae of surgery. Of these 30 women, ten had regional nodal RT and in 20, the axilla was simply observed, i.e. breast irradiation alone. Of those having

Table 3 - Prognostic variables for patients with invasive breast cancerswith a maximum dimension of 10 mm.

Variable	5-Year DMFS	P - Value
Tumor Location		
Central/Inner (n=75)	100%	p = 0.18
Outer (n=88)	97%	
Tumor Size		
2-5 mm (n=33)	100%	
6-9 mm (n=58)	95%	p = 0.15
10 mm (n=77)	98%	
Lymph Node Status		
LN - (n=121)	96%	
LN + (n=17)	100%	p > 0.4
LN unknown (n=30)	100%	
Clinical Tumor Status		
Palpable (n=77)	99%	
Nonpalpable (n=91)	96%	p > 0.7
Histologic Type		
Invasive ductal (n=155)	97%	
Invasive lobular/other (n=13)	100%	p > 0.8
Breast Surgery		
Breast-Conserving (n=145)	98%	p > 0.5
Mastectomy (n=23)	95%	
Age		
< 50 years (n=36)	97%	p > 0.8
> 50 years (n=132)	97%	
Menopausal Status		
Pre & Peri-menopausal (n=40)	97%	p > 0.9
Post-menopausal (n=125)	97%	
Adjuvant Therapy		
None (n=141)	97%	
Chemo (n=9)	100%	p > 0.7
Chemo + hormonal therapy (n=18)	100%	
Histologic Grade		
Well differentiated (n=38)	95%	
Moderately differentiated (n=15)	100%	p > 0.4
Poorly differentiated (n=13)	100%	
Not graded (n=102)	98%	

Table 4 - Pathologic positive nodes by tumor size.

Ratio of the number with positive axillary nodes to total number having axillary dissection

Size	Total		
2mm	0/4	0%	
3mm	0/4		
4mm	0/5		
5mm	0/10		
6mm	1/8	12.8%	14.7%
7mm	3/12		
8mm	1/19		
9mm	0/9	15.8%	
10mm	12/67		
TOTAL	17/138 (12.3%)		

elective AXD, positive nodes were found in 17 (12.3%), of which 16 had one to three positive nodes, and one had 4 involved nodes. As shown in Table 4, the probability of positive nodes found in the AXD specimen increased, albeit not significantly, with increasing tumor size (0% for those < 5 mm vs 14.7% for those 6-10 mm, p = 0.08). Despite the variation in the management of the axilla, i.e. surgery alone (76%), surgery + RT (6%), RT alone (6%), or observation (10%), not one patient has had a lymph node recurrence. Furthermore, DMFS was not significantly affected by the status of the axilla, with 5-year DMFS rates of 100% for positive nodes, 96% for negative nodes, and 100% in the 30 women who did not have AXD, p > 0.4.

The 5-year DMFS was better in women with cancers 2-5 mm in size (100%), compared to those with tumors 6-9 mm (95%), or 10 mm (98%), although statistical significance was not achieved, p = 0.15.

The location of the primary was known in 163 patients; not one with a central or inner quadrant primary developed distant metastases, compared to 3% in those with outer quadrant tumors. The difference was not statistically significant, however (p = 0.18).

Twenty-three patients had mastectomy with or without AXD, and the 5-year DMFS for these patients was 95%, compared to 98% in the group having breast conserving surgery with or without AXD and radiotherapy, p > 0.5.

Patients with palpable tumors did not fare worse than those with clinically occult lesions, p > 0.7, even though the cancers tended to be a bit larger in the former group. Distant relapses were observed in 3% of the women with invasive ductal cancers. None of the nine patients with other histologic types developed distant metastases, p > 0.8. Menstrual status, age, histologic grade, and systemic therapy were not found to significantly impact DMFS.

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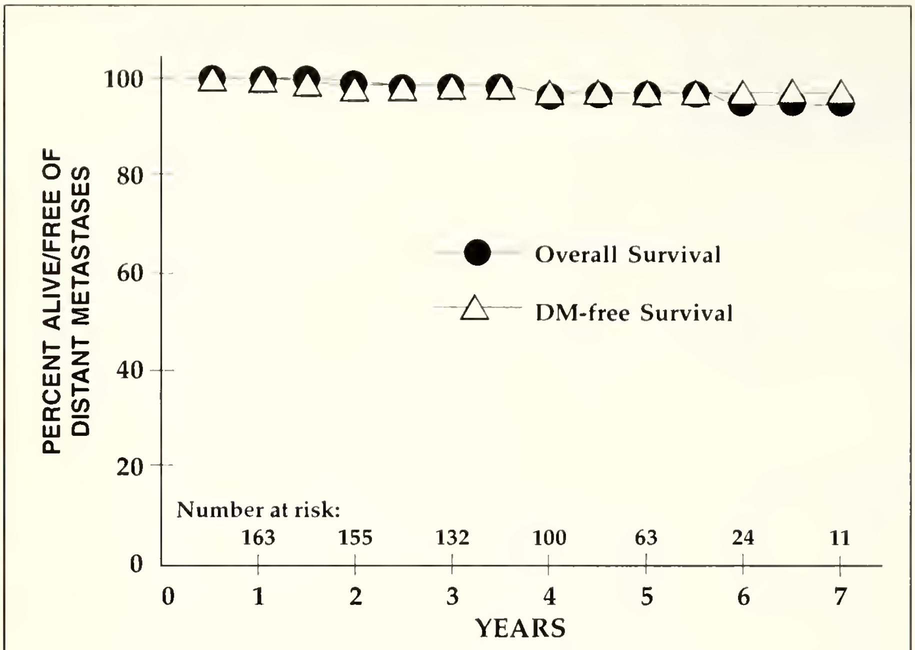

Figure 1. **Actuarial survival and survival free of distant metastases for the entire study population.**

DISCUSSION

The reported relapse-free survival for patients with "minimal breast cancer" exceeds 95%,[4-6] and ranges from 90% to 95% in series of "occult" cancers.[7-10,16] This data is compromised, however, by the inclusion of patients with non-invasive cancers or tumors over 10 mm in dimension.

In series limited to small invasive cancers, the 5-year cause specific survival (CSS) or relapse-free survival (RFS) varies considerably, ranging from 70% to 99%.[17-19] In the series of Rosen et al., the 20 year RFS for women with node negative cancers < 10 mm was 86%.[20]

In our experience, the prognosis for women with invasive cancers no more than 10 mm in greatest dimension was excellent, with an overall survival and DMFS at 7 years of 95% and 97%, respectively. None of the prognostic variables we analyzed were of statistical significance, most likely because the prognosis overall was so good.

Contrary to previous reports,[16,18,19] in our experience, survival was not impacted by nodal status, perhaps because extensive axillary involvement was seen in only one patient (4 positive nodes). In the SEER survey reported by Carter (17), the 5-year RFS was not markedly different in small cancers with negative nodes (5-year CSS of 99% for $\leq$ 5 mm and 98% for 6-10 mm) or 1-3 positive nodes (95% for $\leq$ 5 mm and 94% for 6-10 mm). Survival was, however, much worse in those with 4 or more lymph nodes involved (59% for $\leq$ 5 mm and 54% for 6-10 mm).

In the present report, DMFS was best in the patients with the smallest primaries ($\leq$ 5 mm), although statistical significance was not achieved. Nevin et al., noted 100% RFS in 20 women with microinvasive cancers no larger than 5 mm,[4] and Tinnemans et al. found that size was the most important prognostic factor by multivariate analysis, p = 0.0076(16).

The role of adjuvant systemic therapy in women with breast cancers < 10 mm is controversial. These authors are of the opinion that it is generally unnecessary, particularly if the lymph nodes are negative and/or the tumor measures $\leq$ 5 mm, given the excellent prognosis in this cohort.[20,21-23]

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New Sex Education Policy - More of the Same

Craig Carmichael, MSMA Medical Student Section Chairman

U.S. Surgeon General Joycelyn Elders plans to expand sex education programs so that children, from kindergarten through high school age, will learn how to practice "safe sex," and become indoctrinated with the idea of using a condom. According to the new Surgeon General, "We taught them what to do in the front seat [of a car]. Now it's time to teach them what to do in the back seat."[1]

In Arkansas, Dr. Elders did just that. While she was director of the state health department, the teenage pregnancy rate in Arkansas climbed from the fourth highest in the nation to the second highest and rates of STD infection increased dramatically as well.[2] The failures in Arkansas suggest that the "safe sex" message does not work, and other evidence agrees. After a thorough review of the literature and the studies conducted from 1980-1987, Stout and Rivara concluded that "there is little or no effect from school-based sex education on sexual activity, contraception, or teenage pregnancy."[3]

Even if Dr. Elder's programs were successful and teenagers used condoms every time they had oral, anal, homosexual, or heterosexual sex, STDs and pregnancies might not decrease significantly. Women who rely on condoms for birth control have a 15% chance of becoming pregnant every year,[4] due in part to the 8% rate at which condoms break or slip off.[5] Condoms are even less effective against STDs. In a study of three New York City clinics, 21% of female patients with STDs reported they had been using condoms regularly.[6] Regarding HIV, a recent meta-analysis from the University of Texas finds that when condoms are used, the chance of contracting HIV from an infected partner is 31% over a year's time.[7] In a separate review of the literature concerning HIV and condoms, two authors concluded, "Evidence for this assumption [that condoms prevent HIV spread]... is not strong.... There is the potential for harm if their use is substituted for abstinence, monogamy, or good judgment."[8]

If condom-based "safe sex" programs can ever hope to succeed, then we must intensify our efforts at increasing sexual restraint, delaying the onset of sexual activity, and limiting the numbers of sexual contacts. Early evidence suggests that such abstinence-based programs could find success. Participants of Sex Respect, an abstinence based program which was tried in 26 public schools, had a 5% pregnancy rate two years after participation in the program, compared to a 9% rate among control groups of students who were not enrolled in the program.[9] When Sex Respect was tried in a St. Louis district, elementary school pregnancies fell from ten a year to none, and middle school pregnancies dropped from 40 a year to 10.[10] One researcher created a program at Emory University for eighth graders from low-income, African-American neighborhoods to help them choose not to have sex. Follow-up studies show that these students are one-fifth as likely to have started having sex as their peers. In a separate study, Emory surveyed 1,000 sexually active girls, asking them what topics they would like information about. Eighty-four percent wanted most of all to learn how to say "no" without hurting the other person's feelings.[11]

But Congress is not willing to give students what they want. Title X programs are the contraceptive based approach and they received $150 million in 1992, while title XX programs which encourage sexual restraint received $1.6 million.[12] Planned Parenthood and the Sex Information Education Council of the U.S. (Siecus) are lobbying hard for curricula which encourages students to explore their sexuality, telling them that all forms of sexual behavior can be fulfilling, pleasurable, acceptable, and safe when done with a condom, and that the student's parents need not know that they are experimenting with sex. Planned Parenthood attorneys have sued (sometimes successfully) several school districts for accepting abstinence-based curricula, claiming that teaching sexual restraint violates prohibitions against teaching religion, or that it violates the students' privacy by interfering with their "rights to make personal, intimate, and private decisions with respect to their bodies."[13] Is it an invasion of privacy to tell

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children that the more they restrict their sexual activity, the safer they will be from STDs and pregnancy? Is it religious to teach them that they can best say "no" and control their thoughts and desires if they have a positive self-image and self-edifying hobbies and interests?

Times have changed. Today's sexually active 18-year-old women have already averaged as many sexual partners as the present 40-year-old cohort of women have had in their entire lives.[14] School based sex education cannot reverse all of the forces which encourage teenage sexual risk taking, such as family failure, mind altering drugs, television sensuality, and inner-city hopelessness, but it can tell students the truth. It is only when we stop kidding ourselves about the safety of sex with condoms and the mystic power of base desires, that we can make the kinds of changes which are needed to overcome the great health crises facing young people today.

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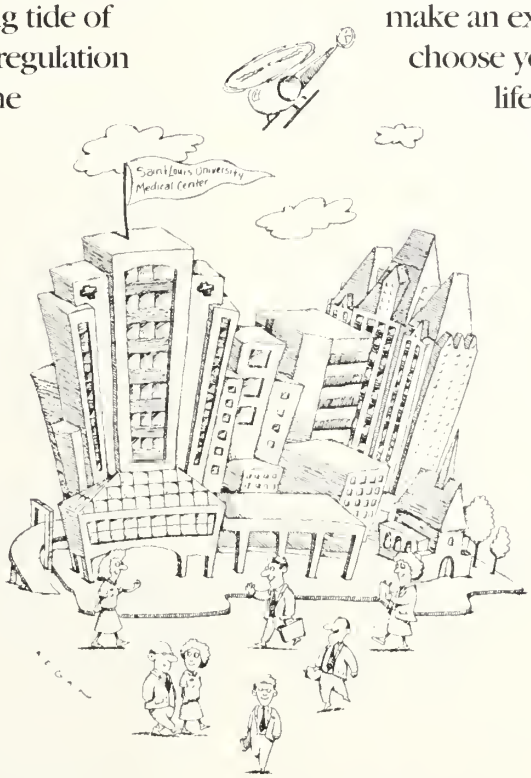
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MEDICAL SCHOOL NEWS

University of Missouri-Columbia

John A. Growdon, MD, a retired Kansas City surgeon, has contributed funds to establish an endowed chairmanship in the name of his friend and a long-time faculty member, **Hugh E. Stephenson, Jr., MD.**

Dr. Stephenson is professor emeritus of surgery and one of the original members of the school's faculty when it became a four-year medical school in 1955. He has served as chairman of the department of surgery, associate dean for clinical affairs and clinical development and interim dean. In the early 1950s, Dr. Stephenson developed the first electrical difibrillator. He is also the author of *Cardiac Arrest and Resuscitation,* now in its fourth edition.

Researchers received a grant from the Robert Wood Johnson Foundation to study the effects of a smoke-free workplace on smokers' health and behavior. **Daniel R. Longo, ScD,** associate professor of family and community medicine and health services management and **Ross Brownson, PhD,** director of the Division of CDPHP of the Missouri Department of Health will conduct a three-phase study to determine if worksite smoking bans reduce or stop smoking by employees.

The School of Medicine received a grant to look at ways of preventing osteoporosis in women with rheumatoid arthritis. The National Institute on Disability and Rehabilitation Research is funding the study.

Approximately 200 women, age 30 to 75, half with rheumatoid arthritis, will be enrolled. Researchers will examine the effects of low-impact aerobics and conditioning exercise in preventing osteoporosis. The principal investigator is **Susan Allen, MD, PhD,** assistant professor in the department of internal medicine's division of endocrinology, diabetes and metabolism and a clinician-investigator at the Harry is Truman Veterans' Hospital. Co-principal investigators are **Marian Minor, PhD,** assistant professor of physical therapy; **Geetha Reddy, MD,** assistant professor of internal medicine; **Sara Walker, MD,** professor of internal medicine; and **Gerald Browning, PhD,** assistant professor of physical therapy.

MU has merged the department of pathology with the department of anatomy and neurobiology. The purpose is to combine one of the important basic science departments with a strong, related clinical department. The new department is called the department of pathology and anatomical sciences. **John Townsend, MD,** former chairman of pathology, will lead the merged programs.

William A. Sly, MD, professor and chairman of the department of biochemistry and molecular biology, received a five-year renewal grant from the National Institute of Diabetes and Digestive and Kidney Diseases to continue research on carbonic anhydrase deficiencies.

St. Louis University

Three assistant professors of pediatrics at St. Louis University's Cardinal Glennon Hospital received one-year grants from Hoffman-LaRoche Inc. to study the drug flumazenil. It is used in adults to reverse the effects of sedation or overdose caused by benzodiazepines.

Gary M. Albers, MD, will study flumazenil when used in children to reverse the effects of benzodiazepines given during a fiberoptic bronchoscopy. **John R. Peters, MD,** will study the drugs use in children to reverse the depressant effects of benzodiazepines when given to sedate them for emergency room procedures. **Anthony J. Scalzo, MD,** will evaluate the drug when used to reverse the signs and symptoms of a known, suspected or possible benzodiazepine overdose in children.

George T. Grossberg, MD, professor and vice chairman of the department of psychiatry and human behavior and director of the division of geriatric psychiatry, received a one-year grant from Glaxo Research Institute to further studies on the drug Ondansetron to treat Alzheimer's disease. Preliminary research indicates the drug helps elderly people improve and maintain cognitive functioning. Researchers discovered that low doses may enhance neurotransmitter levels. This is the second phase of research and will focus on dosage. For information about volunteering, call (314)577-8741.

Researchers are taking part in the largest cancer prevention trial ever done with men. The seven-year study is being sponsored by the National Cancer Institute, a part of NIH. It will involve 18,000 men and will be carried out in 222 sites across the U.S.

Urologists are studying the effectiveness of the drug finasteride in preventing prostate cancer in men age 55 and older. It reduces levels of the hormone DHT which is known to be important for the growth of prostate cells. Male volunteers, age 55 or older, who are generally healthy and prostate cancer free, but who are at high risk for developing prostate cancer are needed. Participants receive free prostate cancer screenings and medication through the study. To volunteer, call (314)268-5259.

The Anheuser-Busch Eye Institute of St. Louis is now using the Alcon Surgical SERIES 20000 LEGACY for phacoemulsification. This system provides surgeons with computer-guided feedback, giving them greater control than standard phacoemulsification. It also has a device for softening the cataract prior to phacoemulsification.

The division of behavioral medicine and HealthLine Corporate Health Services have opened an outpatient treatment program for people suffering from chronic pain. The Day Treatment Program offers a half day of intensive therapy combining rehabilitative, medical and behavioral treatments. For information call (314)577-8707.

Washington University

A new blood test developed at Washington University may make diagnosing heart attacks in patients more accurate. The test measures blood levels of the protein troponin I. Abnormal levels of troponin I is a sensitive signal that heart damage has occurred. The protein muscle brain creatine kinase (MB CK) is usually used to diagnose heart attacks. However, MB CK can be elevated because of damage to skeletal muscle without heart damage. The study included 215 people known to have elevated MB CK for reasons other than heart attack. Of the subjects, 37 had skeletal muscle injury, 10 had chronic muscle disease, nine were marathon runners, and 159 had chronic renal disease. The goal was to discover whether tropinin I, like MB CK, can be elevated in the absence of heart damage. Although many subjects had elevated levels of MB CK, tropinin I was elevated in only the six people who were found to have heart damage.

Depression may trigger lethal heart rhythms in people who have heart disease. Previous studies have shown that about one in five cardiac patients also suffers from depression. **Robert M. Carney, PhD,** associate professor of medical psychology in psychiatry, completed a study establishing a link between depression and ventricular tachycardia. Of the 103 patients studied, 20 percent, met the criteria for clinical depression. Five of the depressed patients, 23.8 percent, experiences episodes of VT during a 24-hour period in which they were hooked to heart monitors. Only three non-depressed (3.7 percent of the study population) had episodes of VT while being monitored. Heart patients with depression are between six and seven times more likely to have episodes of VT than those who are not depressed.

Other factors may contribute to the heart disease and higher death rate in depressed patients with heart disease. They are more likely to smoke and are less likely to adhere to prescribed treatment. Another possible explanation is the connection between increased activity in the sympathetic nervous system which can result in VT.

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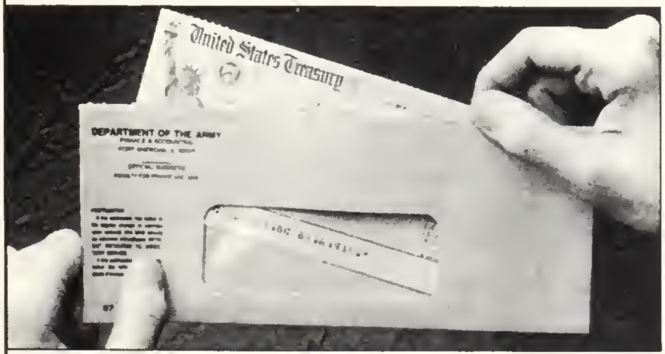

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NEW MEMBERS

❖ **Steven C. Bailey, MD,** 1834 Broadway, Cape Girardeau, MO 63701, has become a member of the Cape Girardeau County Area Medical Society. Dr. Bailey received his degree at the Chicago Medical School in 1984. He completed his residency at the University of California, San Francisco. Dr. Bailey specializes in cardiovascular thoracic surgery.

❖ **Tim E. Baker, MD,** 10 Franklin St., Washington, MO 63090, has become a member of the Franklin-Gasconade-Warren County Medical Society. Dr. Baker received his medical degree at St. Louis University in 1988. He completed his residency at USAF Medical Center, Keesler, Biloxi, MS. Dr. Baker specializes in internal medicine.

❖ **Jeffrey J. Behrens, MD,** 1000 E. Primrose, Suite 555, Springfield, MO 65807, has become a member of the Greene County Medical Society. Dr. Behrens received his medical degree at the University of South Dakota in 1984. He completed his residency at Brooke Army Medical Center, San Antonio, TX. Dr. Behrens specializes in orthopedic surgery.

❖ **Larry J. Carey, MD,** 3231 S. National Ave., Springfield, MO 65807, has become a member of the Greene County Medical Society. Dr. Carey received his medical degree at the University of Kansas in 1977. He completed his residency at Kansas University Medical Center. Dr. Carey specializes in family practice.

❖ **Jennifer L. K. Clark, MD,** Columbia Orthopaedic Group, 400 Keene St., Columbia, MO 65201, has become a member of the Boone County Medical Society. Dr. Clark received her medical degree at Quillen-Dishner College of Medicine, TN, in 1989. She completed her residency at the University of Missouri-Columbia. Dr. Clark specializes in physical medicine and rehabilitation.

❖ **Edward V. Colapinto, MD,** University Hospital & Clinics, Dept. of Surgery, N522, 1 Hospital Drive, Columbia, MO 65212, has become a member of the Boone County Medical Society. Dr. Colapinto received his medical degree at the University of Toronto, Canada, in 1982. He completed his residency at the University of Toronto. Dr. Colapinto specializes in neurosurgery.

❖ **Brian D. Dieterle, MD,** 221 Skaggs Rd., Suite 201, Branson, MO 65616, has become a member of the Tri-Lakes County Medical Society. Dr. Dieterle received his medical degree at the American University of the Caribbean, Plymouth, Montserrat, in 1988. He completed his residency at St. Luke's Hospital, St. Louis. Dr. Dieterle specializes in internal medicine.

❖ **C. Byron Faulkner, MD,** 3800 S. National, Suite 500, Springfield, MO 65807, has become a member of the Greene County Medical Society. Dr. Faulkner received his medical degree at Johns Hopkins School of Medicine in 1989. He completed his residency at Will's Eye Hospital, Philadelphia. Dr. Faulkner specializes in ophthalmology.

❖ **Alan E. Hillard, MD,** University of Missouri, Health Sciences Center, Diagnostic Radiology, M210, 1 Hospital Drive, Columbia, MO 65212, has become a member of the Boone County Medical Society. Dr. Hillard received his medical degree at the University of Missouri-Columbia in 1982. He completed his residency and a fellowship at the University of Utah. Dr. Hillard specializes in diagnostic radiology.

❖ **Ellis A. Ingram, MD,** University of Missouri, Health Sciences Center, Dept. of Pathology, Columbia, MO 65212, has become a member of the Boone County Medical Society. Dr. Ingram received his medical degree at the University of Michigan in 1974. He completed his residency at the University of Missouri-Columbia. Dr. Ingram specializes in pathology.

❖ **Amie C. Jew, MD,** Suite 130, 1000 E. 50th, Kansas City, MO 64110, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Jew received her medical degree at the University of Wisconsin in 1989. She completed her residency at Kansas University Medical Center. Dr. Jew specializes in general surgery.

❖ **Francisco J. Lammoglia, MD,** 3937 Sherman, St. Joseph, MO 64506, has become a member of the Buchanan County Medical Society. Dr. Lammoglia received his medical degree at the University of Kansas in 1985. He completed his residency at the University of Kansas. Dr. Lammoglia specializes in cardiovascular disease.

❖ **Susan L. Lee, MD,** 11201 Colorado Ave., Kansas City, MO 64137, has become a member of the Metropolitan Medical Society. Dr. Lee received her medical degree at the University of Missouri-Kansas City in 1989. She completed her residency at Baptist Medical Center. Dr. Lee specializes in family practicie.

❖ **Gary S. Olson, MD,** 14 Doctors' Park, Cape Girardeau, MO 63701, has become a member of the Cape Girardau County Area Medical Society. Dr. Olson received his medical degree at the University of Wisconsin in 1977. He completed his residency at Phoenix Hospitals Affiliated Pediatric Program. Dr. Olson specializes in pediatrics.

❖ **David M. Ota, MD,** Ellis Fischel Cancer Center, 115 Business Loop 70 West, Columbia, 65203, has become a member of the Boone County Medial Society. Dr. Ota received his medical degree at the University of Chicago Pritzker School of Medicine in 1973. He completed his residency at the University of Texas-Houston and a fellowship at M.D. Anderson. Dr. Ota specializes in oncology.

❖ **Kenneth W. Retter, MD,** #25 Doctors' Park, Cape Girardeau, MO 63701, has become a member of the Cape Girardeau County Area Medical Society. Dr. Retter received his medical degree at Indiana University in 1985. He completed his residency at the Southeast Michigan Area Health Education Center, Kalamazoo, MI. Dr. Retter specializes in cardiology.

❖ **Curtis J. Richardson, MD,** 1502 N. 36th, St. Joseph, MO 64506, has become a member of the Buchanan County Medical Society. Dr. Richardson received his medical degree at the University of Kansas in 1988. He completed his residency at HCA Wesley Medical Center, Wichita, KS. Dr. Richardson specializes in obstetrics and gynecology.

❖ **James E. Riosas, MD,** 4900 Swope Parkway, Kansas City, MO 64130, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Riosas received his medical degree at the University of Missouri-Kansas City in 1989. He completed his residency at Truman Medical Center. Dr. Riosas specializes in obstetrics and gynecology.

❖ **Pradeep K. Sahota, MD,** University Hospital & Clinics, Div. of Neurology, M741, 1 Hospital Drive, Columbia, MO 65212, has become a member of the Boone County Medial Society. Dr. Sahota received his medical degree at Christian Medical College, Punjab University, Ludhiana, Punjab, India, in 1980. He completed his residency at the University of Missouri-Columbia and fellowship at Duke University Medical Center. Dr. Sahota specializes in neurology.

❖ **Richard A. Schmaltz, MD,** University Hospital & Clinics, Div. of Cardiothoracic Surgery, N507, Columbia, MO 65212, has become a member of the Boone County Medial Society. Dr. Schmaltz received his medical degree at the University of South Dakota in 1977. He completed his residency and fellowship at the University of Missouri-Columbia. Dr. Schmaltz specializes in cardiothoracic surgery.

❖ **Amolak Singh, MD,** University Hospital & Clinics, Div. of Nuclear Medicine, 2N19, 1 Hospital Drive, Columbia, MO 65212, has become a member of the Boone County Medial Society. Dr. Singh received his medical degree at the Guru Nanak Medical College, Guru Nanak University, Amritsar, Punjab, India, in 1972. He completed his residency at the Ottawa Civic Hospital & McGill University. Dr. Singh specializes in nuclear medicine.

❖ **Donald P. Spandone, MD,** University of Missouri, Health Sciences Center, Dept. of Surgery, Health Sciences Center, M584, 1 Hospital Drive, Columbia, MO, has become a member of the Boone County Medial Society. Dr. Spandone received his medical degree at the State University of New York in 1981. He completed his residency at the State University of New York. Dr. Spandone specializes in general surgery.

❖ **Gary L. Upton, DO,** Family Health Care of Columbia, 1506 East Broadway, Columbia, MO 65201, has become a member of the Boone County Medial Society. Dr. Upton received his doctor of osteopathy at the Texas College of Osteopathic Medicine, University of North Texas, in 1990. He completed his residency at the University of Missouri-Columbia. Dr. Upton specializes in family practice.

❖ **Mark J. Vellek, MD,** 3401 Berrywood Drive, Suite 303, Columbia, MO 65201, has become a member of the Boone County Medical Society. Dr. Vellek received his medical degree at the University of Minnesota in 1986. He completed his residency at Barnes Hospital. Dr. Vellek specializes in hematology and oncology.

❖ **Sandra L. Visner, MD,** 1900 S. National, Suite 1950, Springfield, MO 65804, has become a member of the Greene County Medical Society. Dr. Visner received her medical degree at the University of Missouri-Columbia in 1986. She completed her residency at St. Luke's Hospital, Kansas City. Dr. Visner specializes in general surgery.

RESIDENTS

Dean A. Mayer, MD
Genelle J. Slagle, MD
Kevin R. Roach, MD
Stacy C. Stevens, MD

IN MEMORIAM

■ **Anthony F. Catanzaro, Sr., MD,** St. Louis, Missouri, died September 29, 1993, at age 80. Dr. Catanzaro received his medical degree at St. Louis University in 1939. He was in private practice until he retired last year. Dr. Catanzaro was on the staffs at St. John's Mercy Medical Center and Incarnate Word Hospital. He served in the Army in the South Pacific during World War II. Dr. Catanzaro was a member of the American Academy of Family Physicians.

■ **Milton T. English, Jr., MD,** Kirksville, Missouri, died October 4, 1993, at age 79. Dr. English received his medical degree at Washington University in 1941. He served in the Army Medical Corps after graduation. He returned to Kirksville in 1947 and practiced at the Grim-Smith Hospital. He retired in 1991. Dr. Milton was a member of the American Society of Abdominal Surgeons.

■ **Harold A. Franklin, MD,** Clayton, Missouri, died October 6, 1993, at age 72. Dr. Franklin received his medical degree at Washington University in 1945. He served in the Army Medical Corps during World War II. He was in private practice in St. Louis for 32 years. He retired in 1983. Dr. Franklin was past president of Incarnate Word Hospital and a former chief of cardiology at St. Anthony's Medical Center. He also a former staff member at Jewish Hospital and faculty member at St. Louis University. Dr. Franklin was a member of the American Society of Internal Medicine and the American College of Cardiology.

■ **Herman J. Hausheer, MD,** Independence, Missouri, died October 10, 1993, at age 66. Dr. Hausheer received his medical degree at Iowa State University in 1954. He was formerly an assistant clinical professor in obstetrics and gynecology at the University of Missouri-Kansas City for ten years. Dr. Hausheer was past president of the Independence Regional Health Center medical staff, past president of the Kansas City Gynecology Society and past vice president of the Missouri State Medical Association. He was past president of the RLDS Medical and Dental Association. Dr. Hausheer was a founding partner in Hausheer, Braby, Goerz and Associates, Inc. since 1962. He was a member of the American College of Obstetricians and Gynecologists.

■ **Blaine Z. Hibbard, MD,** Leawood, Kansas, died October 3, 1993, at age 75. Dr. Hibbard received his medical degree at the University of Pennsylvania in 1943. He served in the Army during World War II. Dr. Hibbard practice internal medicine for 40 years. He retired in 1983. He was formerly chief of staff at St. Luke's Hospital and an associate professor at the University of Missouri-Kansas City School of Medicine. Dr. Hibbard was past trustee, secretary-treasurer and committee chairman of the American Society of Internal Medicine. He served on the inter-specialty committee of the American Medical Association and the executive committee of the Socio-Economic Research and Education Foundation. He was past president and secretary-treasurer of the Missouri Society of Internal Medicine, which named him Missouri internist of the year in 1981. Dr. Hibbard was past secretary-treasurer and councilman of the Jackson County Medical Society, a committee chairman of the Missouri State Medical Association and a member of the executive committee of Blue Shield of Kansas City. He was a fellow of the American College of Physicians and past president of the Kansas City Society of Internists. Dr. Hibbard was also a member of the American College of Chest Physicians.

■ **Russell H. Palmer, MD,** Palmyra, Missouri, died October 8, 1993, at age 84. Dr. Palmer received his medical degree at Indiana University in 1943. He served as a medical officer in the Army during World War II. Dr. Palmer practiced medicine in Indiana and Iowa before moving to Palmyra in 1976. He retired in 1990. Dr. Palmer was on staff at Hannibal Regional Hospital. He was a member of the Northeast Medical Society, the Missouri State and American Medical Associations and the Missouri Academy of Family Physicians. He was a fellow of the American Academy of Family Physicians.

■ **Michael F. Pernoud, MD,** Chesterfield, Missouri, died September 27, 1993, at age 74. Dr. Pernoud received his medical degree at St. Louis University in 1944. He began private practice in 1950. Dr. Pernoud was on the staffs at St. Mary's Health Center, St. Anthony's Medical Center, and St. John's Medical Center. He was a co-founder and former chief of staff at the St. Louis Eye Hospital. Dr. Pernoud was a member of the American Academy of Ophthalmology and Otolaryngology and the American College of Surgeons.

■ **Clark W. Seely, MD,** Overland Park, Kansas, died October 9, 1993, at age 80. Dr. Seely received his medical degree at the University of Chicago Rush Medical College in 1938. He practiced pediatrics from 1938 to 1982. Dr. Seely was a former staff member at St. Luke's Hospital, Children's Mercy Hospital, St. Joseph Health Center and the University of Kansas Medical Center. He was a former supervisor at the Kansas City General Hospital. Dr. Seely founded Children's Cardiac Center in Kansas City. He was associate professor of pediatrics at the University of Missouri-Kansas City School of Medicine from 1966 to 1982. He also was associate director of medical affairs at Children's Mercy Hospital during that time. Dr. Seely was also a former supervisor at the Richard Cabot Clinic. He was a member of the Kansas City Southwest Clinical Society, the Metropolitan Medical Society of Greater Kansas City, the Missouri State and American Medical Associations, the Kansas City Pediatric Society and the American Academy of Pediatrics.

■ **Daniel Sexton, MD,** Clayton, Missouri, died October 14, 1993, at age 92. Dr. Sexton received his medical degree at St. Louis University in 1924. He was a former assistant professor of clinical medicine at St. Louis University. Dr. Sexton was in private practice for 62 years. He was on the staffs of St. Mary's Health Center, Deaconess Hospital, St. John's Mercy Medical Center, Alexian Brothers Hospital and Firmin Desloge Hospital. He retired in 1985. Dr. Sexton served as president of the St. Louis Medical Society, the American Therapeutic Society, the Mississippi Valley Medical Society, and the Southern Medical Association. He was a member of the Central Society for Clinical Research, the American College of Physicians, the American Society of Internal Medicine and the American Diabetes Association.

■ **Philip T. Shahan, MD,** St. Louis, Missouri, died September 30, 1993, at age 76. Dr. Shahan received his medical degree at Washington University in 1942. From 1953 to 1955 he was a captain in the Air Force and an instructor at the School of Aviation Medicine at Randolph AFB, San Antonio, Texas. Dr. Shahan was in private practice in St. Louis for 44 years before retiring in 1992. He was on the staffs of Barnes, St. Louis Children's, and St. Luke's hospitals. Dr. Shahan was past president of the St. Louis Ophthalmological Society and a former consultant for the Missouri Bureau for the Blind. He was a member of the American Academy of Ophthalmology and Otolaryngology and the American Association of Ophthalmology.

■ **Robert W. Tatkow, MD,** Chesterfield, Missouri, died October 1, 1993, at age 61. Dr. Tatkow received his medical degree at St. Louis University in 1957. He served in the Air Force from 1961 to 1963. Dr. Tatkow was in private practice in St. Louis for 30 years. He was on the staffs of Jewish Hospital, Missouri Baptist Hospital, and DePaul Health Center. Dr. Tatkow was a member of the American Academy of Orthopaedic Surgeons and the American College of Surgeons.

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December

2 & 3 - *Kansas City*: The Heart - 1993. Contact Beth M. Paul, St. Luke's Hospital of K.C., 816/932-2301, fax #816/932-5119.

3 - *St. Louis*: Women's Healthcare Issues '93. Contact Washington University 314/362-6893 in MO, 800/325-9862 interstate.

3 - *Kansas City*: Future Directions in the Management of Fungal Infections. 3 credit hours. Contact Dr. David McKinsey, 816/276-3317.

3 to 5 - *St. Louis*: Practical Anatomy and Surgical Technique Workshop - Approaches to Cranio-Cervical Fixation. Contact St. Louis University, 314/577-8167 or 800/553-2712.

4 - *St. Louis*: GI Update. Contact CME, Washington University, 314/362-6893 in MO or 800/325-9862 interstate.

4 - *St. Louis*: 5th Annual Symposium for Medical Directors in Nursing Homes. 6.75 credit hours. Contact St. Louis University, CME, 314/577-8167 or 800/553-2712.

10 - *Kansas City*: Nuclear Medicine. 5.5 credit hours. Contact The Ed Bixby Institute for Postgraduate Medical Education, 816/276-4306, toll-free: in Missouri - 800/892-5771, ext. 4306; bordering states - 800/821-5140, ext. 4306.

10 to 12 - *Springfield*: ACLS Provider Course. 18 credit hours. Call Donna Willoughby, Cox South, 417/885-4117.

10 to 13 - *Chesterfield*: Advances in Internal Medicine. Contact Barry Kling, University of Missouri, 314/882-4105.

11 - *St. Louis*: Cardiology Seminar. Contact CME, Washington University, 314/362-6893 in MO or 800/325-9862 interstate.

13 - *St. Louis*: City-Wide Radiology Conference by James A. Brink, MD - Spiral CT: Update 1993. Contact R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology, 314/362-7130, fax 314/361-5428.

20 to 22 - *St. Louis*: Practical Anatomy and Surgical Technique Workshop: Temporal Bone Surgical Dissection - Exploring New Surgical Instrumentation with Midas Rex Hands-On Workshop. 16 credit hours. Contact the St. Louis University, CME Office at 314/577-8167 or 800/553-2712.

27 to 31 - *Snowbird, UT*: Drug Therapy for the 90's: An Update in Mechanisms of Action in Clinical Utilization. 18 credit hours. Contact Daniel E. Reichard, George Washington University, 202/994-4285.

January

10 - *St. Louis*: City-Wide Radiology Conference, St. Louis University. Contact R. Gilbert Jost, MD, Chief of Diagnostic Radiology, Mallinckrodt Institute of Radiology, 510 S. Kingshighway, St. Louis, MO 63110, 314/362-7130.

14 - *Springfield*: Pediatric Advanced Life Support Recertification Course. 7 credit hours. Call 417/885-4117.

18 - *Kansas City*: Perinatal Core Curriculum Workshop #1. 5 credit hours. Contact Carol Osborne, St. Luke's Hospital of K.C., 816/932-3737, fax - 816/932-5119.

24 to 26 - *Orlando, FL*: 14th Annual Conference on Peritoneal Dialysis. Contact Barry Kling, University of Missouri-Columbia, 314/882-4105.

24 to 28 - *St. Louis*: The Medicolegal Death Investigator Training Course. 33 credit hours. Contact Mary Fran Ernst, 314/522-6410, ext. 6509.

February

1 - *Kansas City*: Perinatal Core Curriculum Workshop #2. 5 credit hours. Contact Carol Osborne, St. Luke's Hospital of K.C., 816/932-3737, fax - 816/932-5119.

1 to 5 - *San Diego, CA*: 19th Annual Meeting of the Alliance for CME. 13.5 credit hours. Contact Daniel E. Reichard, George Washington University, CME, 202/994-4285, fax 202/994-1791.

14 - *St. Louis*: 8th Annual Daniel R. Biello Memorial Lecture: Henry D. Royal, MD - Pulmonary Embolism: Scientific Challenges. Contact R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology, 314/362-7130.

15 - *Kansas City*: Perinatal Core Curriculum Workshop #3. 5 credit hours. Contact Carol Osborne, St. Luke's Hospital of K.C., 816/932-3737, fax - 816/932-5119.

26 to March 5 - *Barbados*: Topics in Gastroenterology and Internal Medicine. 15 credit hours. Contact Maria Gorrick, George Washington University, 202/994-4285, fax 202/994-1791.

March

1 - *Kansas City*: Perinatal Core Curriculum Workshop #4. 5 credit hours. Contact Carol Osborne, St. Luke's Hospital of K.C., 816/932-3737, fax - 816/932-5119.

4 & 5 - *St. Louis*: The Annual Meeting of the Midwest Gut Club. Contact the St. Louis University, 314/577-8167 or 800/553-2712.

6 to 11 - *Vail, CO*: Update in Clinical Medicine. 19 credit hours. Contact Steven Smith, George Washington University, CME, 202/994-4285, fax 202/994-1791.

10 & 11 - *St. Louis*: Gastrointestinal Surgery: Refresher Course and Update. Contact CME, Washington University, 314/362-6893 in MO or 800/325-9862 interstate.

14 - *St. Louis*: City-Wide Radiology Conference: Theresa McLoud, MD - Computed Tomography of the Pulmonary Parenchyma. Contact R. Gilbert Jost, MD, Chief of Diagnostic Radiology, Mallinckrodt Institute of Radiology, 314/362-7130.

15 - *Kansas City*: Perinatal Core Curriculum Workshop #5. 5 credit hours. Contact Carol Osborne, St. Luke's Hospital of K.C., 816/932-3737, fax - 816/932-5119.

17 to 19 - *St. Louis*: Microsurgery of the Temporomandibular Joints. 20 credit hours. Contact the St. Louis University, CME, 314/577-8167 or 800/553-2712.

18 - *St. Louis*: Laboratory Monitoring of Antithrombotic Therapy. 7 credit hours. Contact the St. Louis University, CME, 314/577-8167 or 800/553-2712.

18 - *Washington D.C.*: Ultrasound in Abdominal Surgery. Contact Maria Gorrick, George Washington University, CME, 202/994-4285, fax 202/994-1791.

24 - *St. Louis*: Neonatal Pharmacology. 6.75 credit hours. Contact Patricia Nash, St. Louis University, 314/577-5631.

25 & 26 - *Springfield*: Pediatric Advanced Life Support Provider Course. 16 credit hours. Call 417/885-4117.

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STUDENT SECTION: Winchell, MA.

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RESIDENT SECTION: Austin, CT; Baker, EK; Bal, DS; Barry, SL; Berenson, CE; Bernard, JP; Bhattacharjee, L; Brunts, JT; Carter, JT; Chou, AH; Colton, ES; Cornelison, DL; Dihenia, BH; Gaffney, LA; Gemperli, AW; Golfinopoulos, D; Hampton, BS; Hattamer, SJ; Husain, S; Kang, MS; Kirila, CE; Lai, EY; Le, PM; Mann, RM; Marvin, RD; Palmer, BJ; Parker, LA; Peet, BJ; Radmanesh, RA; Reddy, VK; Ring, DS; Rumpf, RP; Schrock; LM; Sisillo, S; Thomas, HO; Velloff, TM; Woody, MB and Yang, JY.

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RESIDENT SECTION: Kichrua, GM; Lunberry, JJ; McLaughlin, ST and Stokesbary, SJ.

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Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia a dose-response study. *Clin Cardiol.* 1991;14:146-151.

PRAVACHOL® (Pravastatin Sodium Tablets)

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life (t1/2) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin*, *antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine*, *nicotinic acid*, or *probucol*, no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*, a forward mutation assay in L5178Y TK +/− mouse lymphoma cells, a chromosomal aberration test in hamster cells, and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area ($mg/meter^2$). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS. **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated, adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug.

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma, anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS. **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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Bristol-Myers Squibb Company

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PRAVACHOL is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate.

Active liver disease or unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of pravastatin sodium.

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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